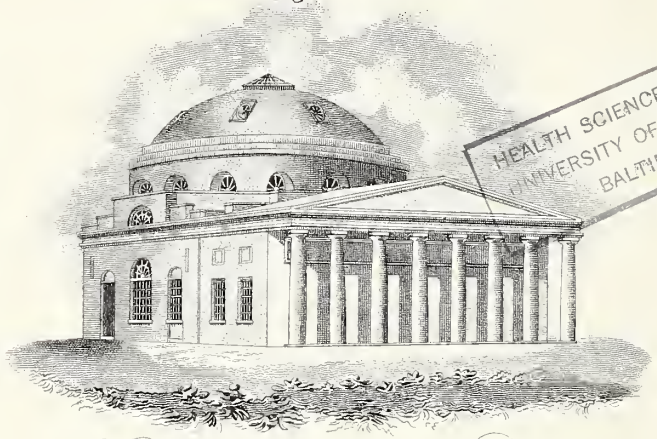
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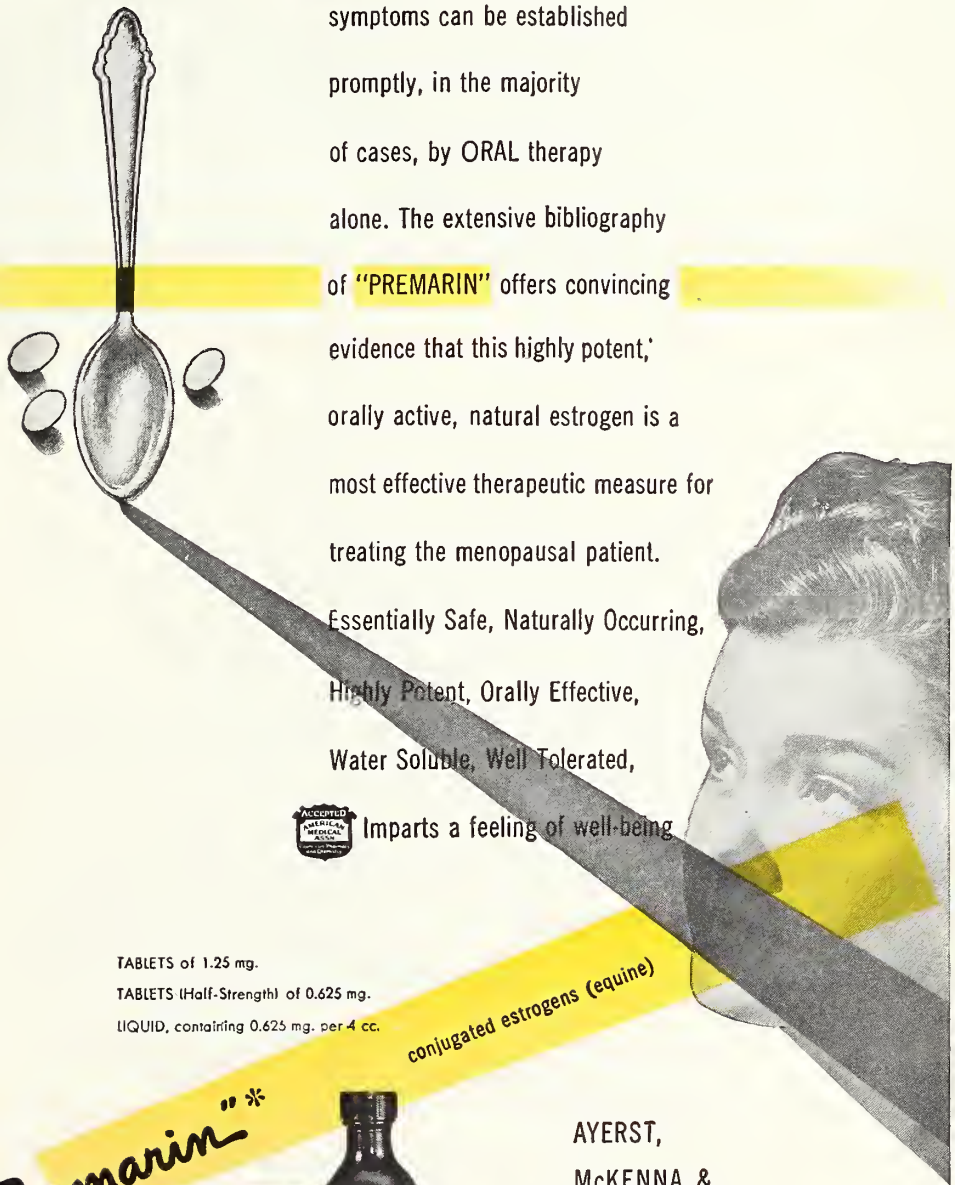
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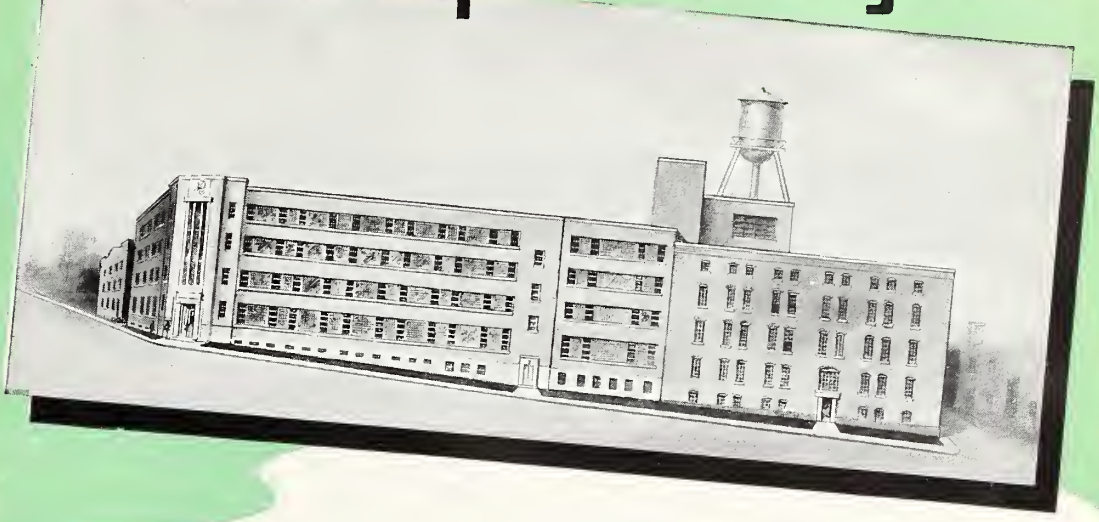
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Bartholomew-Brown	Byron K. Zaring, Columbus	Last Wednesday evening of each month.
Benton	L. P. Muller, Boswell	First Monday of each month.
Boone	C. G. Kern, Lebanon	First Tuesday of each month.
Carroll	Charles L. Wise, Camden	Third Wednesday of each month.
Cass	Will W. Holmes, Logansport	Third Friday of each month.
Clark	J. T. Carney, Jeffersonville	Second Tuesday evening of each month.
Clay	John M. Palm, Brazil	Second Tuesday of each month.
Clinton	T. A. Dykhuizen, Frankfort	First Tuesday night of each month.
Crawford	H. H. Deen, Leavenworth	Dates of meetings variable.
Daviess-Martin	A. G. Blazey, Washington	Fourth Tuesday of each month.
Dearborn-Ohio	J. C. Elliott, Guilford	Last Thursday of each month except July, August.
Decatur	H. S. McKee, Greensburg	Third Wednesday of each month.
DeKalb	Harold Nugen, Auburn	Every third month. (A called meeting.)
Delaware-Blackford	Bruce W. Stocking, Muncie	Third Tuesday of each month.
Dubois	F. P. Williams, Huntingburg	Quarterly.
Elkhart	O. E. Wilson, Elkhart	First Thursday of each month except June, July, August.
Fayette-Franklin	R. H. Elliott, Connersville	Second Tuesday of each month.
Floyd	Phillip Cohn, New Albany	Second Friday of each month.
Fountain-Warren	A. R. Kerr, Attica	Variable.
Fulton	A. E. Stinson, Rochester	First Friday of each month.
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Grant	R. W. Lavengood, Marion	Fourth Thursday of each month.
Greene	George Moses, Worthington	Thursday following second Monday of each month.
Hamilton	Robert F. Harris, Noblesville	Second Tuesday each month except July, August.
Hancock	Joseph L. Allen, Greenfield	Second Wednesday of each month.
Harrison	W. E. Amy, Corydon	Second Wednesday of each month.
Hendricks	W. T. Lawson, Danville	
Henry	R. D. Spindler, New Castle	Third Thursday of each month.
Howard	Joe D. Boughman, Kokomo	First Friday of each month.
Huntington	G. M. Nie, Huntington	First Tuesday of each month.
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11	Max R. Adams, M.D., Flora	O. G. Brubaker, M.D., North Manchester	Huntington, May 21
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LAWS PERTAINING TO MALPRACTICE

MALPRACTICE may be defined in accordance with the derivation of the word, as bad practice. In medicine it is the treatment of a case by a surgeon or physician in a manner contrary to accepted rules and with injurious results to the patient. It may consist of professional misconduct, or of negligence, or of lack of reasonable skill, or of lack of fidelity in the performance of professional duties. In a narrower sense, it could be limited strictly to what pertains to the rendering of professional service; but in the broader and generally accepted sense, it covers any kind of conduct which may be within the activities of a physician in his status of physician, whether concerned directly with professional services or only with acts that grew out of professional relationships.

The common law imposes upon a physician the duty to conform in his treatment of a case to the standard of treatment recognized, accepted and approved by the physicians generally who practice in the same or similar localities, where the service is rendered by a general practitioner. But where it is rendered by a specialist he must conform to the standards of specialists in general and without regard to any particular locality, but having regard to the advanced state of the medical profession with respect to that specialty.

There are, however, certain statutory requirements of physicians, which if not satisfied, render him liable because of the violation of the particular statutes rather than upon a general charge of malpractice. Malpractice actions brought by one person to recover damages against another are usually based on a charge of negligence upon the part of the physician. Among the statutory requirements to be observed by a physician in his practice are the following:

1. The physician is required to make reports regarding births and deaths, and sign the certificates relative thereto.
2. He is required to report concerning what he did, if anything, with respect to the examination and care of the eyes of a child at birth.
3. He is required to report to the Welfare Department the facts regarding congenital deformities.
4. If he makes premarital examinations he must perform the service properly and make proper reports.
5. He must make proper reports regarding communicable diseases, as required by the State Board of Health.
6. He must keep proper records regarding the use of narcotics.
7. Of course, he must obey the laws that pertain in general to all people, including the filing of reports and the payment of income and other taxes, and whatever else may be required of a citizen in general.

The charges made against physicians for malpractice consisting of negligence are of such variety, and are subject to such defenses, and require such conduct in the handling of them that they could not be covered in this article.

PRESERVE THIS ISSUE OF THE JOURNAL

You will find the contents of this issue of THE JOURNAL useful throughout the year, so it is recommended that you keep this copy on your desk. The roster of members of the Indiana State Medical Association is printed both alphabetically and by county societies. In this number, too, are listed personnel of state boards and commissions, officers of various special organizations, explanations of laws affecting medical practice, and much other helpful information. Another "Indiana Medical Year Book" edition of THE JOURNAL will be put out in January, 1948. Meantime, the editors will welcome suggestions as to its contents.

Actions for malpractice based upon negligence may be involved in the treatment of various conditions. The more frequent charges upon which negligence is based involve the following types of cases, which are not stated in the order of their greatest frequency, but merely as the class of cases appearing most frequently in litigation:

a. Failure to produce a satisfactory appearing result in orthopedic cases.
b. Failure to obtain satisfactory results in an operation.
c. The inclosure of foreign objects, such as sponges, in the area of operation.
d. Unsatisfactory results from the use of x-ray and other forms of radiology.
e. Failure to give sufficiently prompt and frequent attention to the patient.
f. Failure to make proper diagnosis.
g. Errors in the administration of drugs or the writing of prescriptions.

The listing of these more common matters involved in malpractice litigation is sufficient to indicate some of the things that would be appropriate to do in the course of one's practice to guard against malpractice actions, or to successfully defend them if they should come in spite of all your efforts.

Suggestions on How Either to Avoid Being Sued or to Defend Successfully

A long list of items to be followed as routine would be difficult to keep in mind; nevertheless a list of items that attorneys find from experience constitutes a means of avoiding being sued, or of winning the case if suit is brought, may be of some help. So the following is submitted:

1. The best way to avoid a suit is not to deserve one—that is, give your whole soul and mind and conscience to your practice, but even if you then fear that your patient is of a litigious disposition, either take great precautions to be in position to produce the evidence necessary to prove absolutely that you performed your whole duty to him, or else terminate your relations with him as early as you can.
2. Be sure, in treating fractures and dislocations, to have an x-ray record completely identifiable by patient's name, date, and number of x-ray, or whatever other way you identify your x-ray films, showing the condition when the patient first called you, and the conditions as they were after your first treatment and after any subsequent treatments, with a final one showing condition at the time of discharge.
3. In the case of fluoroscopic examinations, or of the use of x-ray or other radiation exposure, note the length of time of examination or of treatment.
4. Do not depend entirely on apparatus which itself may be guaranteed to operate perfectly. Be sure that it is in correct operating condition when you are using it.
5. Take pains that radiation is not used where the patient may not be able to stand it because of previous treatments of that nature.
6. Be careful of your diagnosis. Before arriving at a conclusion, weigh and consider all relevant factors, including details of the history, and use the help of every diagnostic aid science has made available, including the obvious ones, such as x-ray, urine and blood tests, pathological and microscopical examinations. If you still have an honest doubt after all these efforts to diagnose, call in a consultant.
7. If your patient refuses to follow the treatment you advise, for instance, to be hospitalized if you advise it, protect yourself by putting your advice in writing and giving the patient a copy, all with adequate proof that you have done so. Or better yet, have the patient sign a written statement to the effect that he refuses to follow whatever of your advice he rejects.
8. Before attempting to treat or operate upon a patient, be honestly certain that you are in fact competent to render the service the particular case requires. If you have a doubt in that regard, call in an expert in that particular type of malady, to act as a consultant or to render the treatment or perform the operation.
9. Give due consideration to whatever your patient tells you regarding any idiosyncracy or allergic conditions he has, or thinks he has.
10. In case of surgery, consider carefully whether it is necessary, and if you decide that it is, be sure that all conditions surrounding the rendering of that service are in as nearly perfect condition as possible. Unsterile surgery, or the failure to make a careful sponge count and record of that fact, or the use of inappropriate anesthetics, can all be the source of trouble for the surgeon who is in charge of the case. This preparation of the conditions in which surgery may be performed applies to the keeping of your instruments and appliances in proper working order and completely up-to-date. Surgical needles should be selected with care as to the size and strength, in relation to the demands that may be placed upon them, and the reliability of the manufacturer of them.
11. Do not work in special fields, such as the eye or radiology, unless you are sure that you are adequately prepared for it.
12. Keep abreast of the times. The failure to use the newest forms of treatment have been the cause of a number of malpractice cases.
13. Do not promise more than is justifiable from your treatment. While it is recognized that an encouraging and hopeful manner may be of some therapeutic value, nevertheless an

over-enthusiastic prognosis sometimes leads to disappointments, which result in malpractice suits.

14. Be tactful and fair to your fellow-practitioners. A spirit of criticism and unfriendliness, leading to careless remarks and caustic comments, frequently causes malpractice cases. Where that spirit develops in a medical group it is unfortunate for all of them.
15. Finally, keep adequate case records sufficiently complete to establish the facts of your case. These should be kept for not less than two years, if the treatment has been of an adult. But if it has been of a child, then they should be kept until the child is at least twenty-three years old.

When all of these things are done you may still have malpractice cases, and for that reason this article proceeds to a little discussion of the conduct of a physician in court.

PHYSICIANS IN COURT

ONE who has not had the experience of going through a number of trials is little aware of the dramatic element involved in the trial of a law suit. The purpose of each contending party is to present his case in a convincing manner. What might offend a juror's sensibilities may be as important in a close case as a point of law covered by an instruction, or as the evidence of a witness on some important fact in the case. The trial lawyer acquires by experience, if he is sufficietly observant to benefit by experience, some knowledge as to what to avoid, what to do, what to play up and what to play down—all for the purpose of presenting his case in a manner that will be convincing to the jury, and at the same time of throwing the spotlight upon the weak places in his adversary's case.

There are rules of evidence which have grown out of juridical experience and which are of value in getting at the truth of a case. Some of these rules may seem annoying and unreasonable to the person who has not had experience in those matters. But whether the rules of trial procedure are wise or unwise, at least they do not yield instantly to the effort of some person who has just come into court, to revise them for what he thinks would serve his convenience or assist in the achievement of justice.

So the physician should permit his lawyer to run the case and not do it himself. If he does not have confidence that his lawyer can manage the case wisely, then he should get another lawyer. If he does not believe that any lawyer can run it wisely, then as a general rule he might as well give up without a trial.

There are a few general rules, the mere statement of which might be of aid to a physician in court.

1. Tell the truth in response to a proper question. If the question is not a proper one, let your attorney make the objection to the question and then if the court overrules the objection and orders you to answer, go ahead and tell the truth. It is proper for the court to instruct the jury that if they believe any witness willfully testified falsely in regard to a material matter they may disregard his entire testimony.

2. Be prepared to testify. Confer with your attorney as to what facts he expects to elicit by your testimony, then get names, persons, places, figures, dates, and all other facts about which you probably will be asked, clearly in mind. If you have papers or books that would help you to be accurate, bring them with you to court. If you are going to testify as an expert, study the text books and the latest literature on the subject on which you expect to testify, and bring them along to court.

3. Talk loud enough to be heard, and do not talk just to yourself or to the inanimate objects in the court room, but talk to the judge, if he is asking the questions, and to the jury, if the jury is considering the case.

4. Be straightforward in your answers, neither talking down to the jury nor up to the judge. Use whatever technical or medical phraseology is appropriate to use, but be sure that after using such words as may not be familiar to the layman that you immediately explain in lay language the meaning of the word you have used.

5. Do not put on any airs whatever of superiority to judge or jury, or the attorneys on either side. There is nothing more disarming to your opponent nor more convincing to a jury than modesty, courtesy, and familiarity with the subject on which you are being examined.

6. Listen carefully to the questions before you answer them, and be sure you have heard correctly and that you understand what is meant by the question. If you do not understand, say so. The judge will have the question read to you or will have the questioner reframe his question.

7. Do not assume the role of advocate, nor volunteer information not responsive to the question asked. If there is something you think should be told the jury which would not be in response to any question, wait until you are excused from the witness stand, then go to the attorney for the party in whose behalf you are appearing and tell him what information you think should be brought out which you have not testified to. He can put you back on the stand and ask you about that omitted information.

8. Under no circumstances should you lose your temper or attempt to be facetious, caustic or sarcastic with your questioner, no matter what he does. Nothing shows up a discourteous, flippant, sarcastic or angry lawyer so much as a well-

informed witness who never fails to be courteous and self-controlled. That is a way of killing him with kindness.

As Mr. Stryker says in his book "Courts and Doctors," concerning the doctor on the witness stand:

"In an atmosphere surcharged with tension, his nerve must not snap, under provocation he must not lose his temper, when met with marked discourtesy he must remain polite, under attack he must keep cool. He is the centre of all eyes in the court room, he is especially the cynosure of the twelve pairs of eyes in the jury box. His every word, inflexion, mannerism, even the way he moistens his lips or asks for a drink of water is under the surveillance of the most attentive of all audiences. Everything he does as well as says is watched, measured, weighed and judged. His whole self is in the crucible. Strong men have wilted under this ordeal, egoists have been deflated, braggarts have been written down, tricksters have been exposed, and liars have been caught redhanded in their perjury. It is well then that one who is about to mount the witness stand should consider seriously the nature of the task he is about to assume."

PRIVILEGED COMMUNICATIONS

THE expression "privileged communication" is applied to two kinds of information:

1. Information which a person may give to another because the first one owes the duty to the other to give him that information.

2. Information which a person has concerning another about which he cannot be compelled to testify as a witness.

It is the latter type of privileged communication with which this article deals.

The law in Indiana makes certain persons incompetent as witnesses. By incompetent is not meant incapable on account of lack of ability. It means without the right to testify. The statute regarding incompetent witnesses makes the following persons incompetent witnesses: Persons under ten years of age unless it appears that they understand the nature and obligation of an oath; attorneys as to confidential communications made to them or advice given to them in their profession; "physicians, as to matter communicated to them, as such, by patients, in the course of their professional business, or advice given in such cases"; clergymen as to confessions or admissions made to them in the course of discipline enjoined by their churches; and husbands and wives with respect to communications made to each other.

The clause pertaining to physicians has been construed to include everything that the physician learns in connection with his professional services, whether spoken language of the patient or observations of his condition and conduct. The mere fact that a person may regularly be the patient of a physician does not make all information which the physician receives from him incompetent evidence. It is only the information that he obtains in the course of his professional business that is incompetent. So it has been held that a physician may be compelled to testify as to what he observes when he is attempting to collect a fee, for the collection of his fee is not professional service.

The privilege under this statute is the privilege of the patient and not of the physician. The patient may waive the privilege, and if he does so then the physician may be compelled to testify as to these professional matters. The patient may waive the privilege either expressly or by implication. It is waived by implication if he sues the physician for malpractice in connection with the services involved. If he puts in issue in a trial in court the facts of his physical condition which may or may not be in relation to the treatment given by the physician to the patient, then the privilege is waived and all physicians who know of the particular physical condition may be compelled to testify.

If the physician gives confidential information where the privilege has not been waived, either by implication or expressly, the physician may be liable for the violation of the patient's confidence. Where the law requires reports of any kind to be made such requirements constitute exceptions from the privilege, and with respect to making of them there is no violation of a confidence. But if the physician goes further in giving publicity to some reports than merely to make them, he would be guilty of a violation of the patient's confidence, unless the patient waived the privilege. Many reports made to welfare or health departments are required by law to be kept confidential, both by the reporter and by the receiver of the reports. They can be used only for the purpose stated in the statutes requiring the reports to be made, where they are to be considered not as public reports but as confidential communications.

A physician who appears as a witness may properly raise the question himself as to whether or not a question asked him would require the violation of his duty with respect to privileged or confidential communications. But if he does not do so and answers questions without making any objection he is not liable, for it is the duty of the court and of the attorneys in the case to protect the physician as a witness against any violation of confidential relationships by making timely objections to questions, the answers to which might constitute such violations. The physician as a witness is not required to determine for himself how far he can go in testifying to matters he has learned in his professional capacity. That is the responsibility of the judge.

NARCOTIC LAWS

There are State and Federal narcotic laws in force in Indiana.

THE STATE LAWS

It is unlawful for a physician "to write, issue, deliver or dictate either directly or indirectly any prescription to or for any habitual user of any" of the following drugs: "cocaine, alpha or beta eucaine, opium, morphine heroin, or any salt, or any compound, or any derivative of the foregoing substances, or any of their salts or compounds or derivatives," except that nothing in the Act "shall be construed to prevent the legitimate administering of said drugs, their salts, compounds and derivatives by a duly registered practicing physician, duly licensed veterinarian or duly licensed dentist." (Burns 1942, Section 10-3502.)

The penalty is a fine of not less than $25 nor more than $500 and imprisonment of not less than ninety days nor more than one year. But each succeeding offense constitutes a felony, the penalty of which is the revocation of a physician's license, a fine of not less than $200 nor more than $1,000, and imprisonment for not less than one year nor more than eight years.

It is unlawful for any person except a registered pharmacist, licensed physician, podiatrist, veterinarian or dentist to have any cannabis sativa and indica in his possession except upon a written prescription by such professional person who may lawfully have it.

The law contains the following definitions of certain of the prohibited commodities:

"Coca leaves" includes cocaine and any compound, manufacture, salt, derivative, mixture, or preparation of coca leaves, except derivatives of coca leaves which do not contain cocaine, ecgonine, or substances from which cocaine or ecgonine may be synthesized or made.

Exemptions under the Act are stated as follows:

Except as otherwise in this act specifically provided, this act shall not apply to the following cases:

(1) Prescribing, administering, dispensing, or selling at retail of any medicinal preparation that contains in one (1) fluid ounce, or if a solid or semisolid preparation, in one (1) avoirdupois ounce, (a) not more than two (2) grains of opium; (b) not more than one-quarter of a grain of morphine or any of its salts; (c) not more than one (1) grain of codeine or of any of its salts; (d) not more than one-eighth of a grain of heroin or of any of its salts; (e) not more than one-half of a grain of extract of Cannabis; nor more than one-half of a grain of any more potent derivative or preparation of Cannabis; (f) not more than one-quarter of a grain of isonipecaine or any of its salts; (g) and not more than one of the drugs named above in clauses (a), (b), (c), (d), (e), and (f).

(2) Prescribing, administering, dispensing, or selling at retail of liniments, ointments, and other preparations, that are susceptible of external use only and that contain narcotic drugs in such combinations as prevent their being readily extracted from such liniments, ointments, or preparations, except that this act shall apply to all liniments, ointments, and other preparations, that contain coca leaves in any quantity or combination.

Narcotic Regulations

The report that in various communities of the country there have been violations of the Federal narcotic law and regulation by druggists in accepting narcotic prescriptions over the telephone prompts the publication of the following Article 172 of Regulations No. 5 of the federal law:

"Article 172: Telephone Orders:—The furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent, pursuant to a telephone order, provided the employee or agent is supplied with a properly prepared prescription before delivery is made, which prescription shall be turned over to the druggist and filed by him, as required by law."

Physicians are urged to comply with the Federal narcotic law by writing all narcotic prescriptions with ink or indelible pencil and not to request or expect the druggists to violate the above regulation.

Further, physicians are reminded that it is a violation of the Federal narcotic law for a druggist to refill a narcotic prescription. If a druggist fills an order for narcotics reading "Refill Rx No. —," he is refilling a narcotic prescription and would be in violation of the law.

The exemptions authorized by this section shall be subject to the following conditions:

(a) No person shall prescribe, administer, dispense, or sell under the exemptions of this section, to any one person, or for the use of any one person or animal, any preparation or preparations included within this section, when he knows, or can by reasonable diligence ascertain, that such prescribing, administering, dispensing, or selling is for the purpose of satisfying addiction.

(b) The medicinal preparation, or the liniment, ointment, or other preparation susceptible of ex-

ternal use only, prescribed, administered, dispensed, or sold, shall contain, in addition to the narcotic drug in it some drug or drugs conferring upon it medicinal qualities other than those possessed by the narcotic drug alone. Such preparation shall be prescribed, administered, dispensed, and sold in good faith as a medicine, and not for the purpose of evading the provisions of this act.

Nothing in this section shall be construed to limit the kind and quantity of any narcotic drug that may be prescribed, administered, dispensed, or sold, to any person or for the use of any person or animal when it is prescribed, administered, dispensed, or sold, in compliance with the general provisions of this act. (Burns 1945 Supp., Section 10-3526.)

"Opium" includes morphine, codeine, and heroin, and any compound manufacture, salt, derivative, mixture, or preparation of opium, but does not include apomorphine or any of its salts.

"Cannabis" includes all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or resin, including specifically the drugs known as American hemp, marihuana, Indian hemp or hasheesh, as used in cigarettes or in any other articles, compounds, mixtures, preparations, or products whatsoever, but shall not include the mature stalks of the plant; fiber produced from such stalks; oil or cake made from the seeds of such plant; any compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom); fibre, oil or cake; or the sterilized seed of such plant which is incapable of germination.

"Narcotic drugs" means coca leaves, opium, cannibus, isonipecaine and every substance neither chemically nor physically distinguishable from them. Isonipecaine shall mean any substance identified chemically as 1-methyl-4-phenyl-piperidine-4-carbolic acid ethylester, or any salt thereof, by whatever trade name designated. (Burns 1945 Supp., Section 10-3519.)

2. THE FEDERAL LAWS

The federal laws for the regulation of traffic in narcotics are based upon the power of the federal government in the matter of raising revenue, and not upon any police power. The federal government does not exercise police power with respect to matters affecting the morals, health, and safety of the public generally. That is a function of the state government. But the narcotic laws get at this thing through the issuing of various types of licenses to deal in narcotics.

There is a license regulating importers, manufacturers, producers and compounders; one regulating wholesale dealers; one regulating retail dealers; and one regulating physicians, dentists, veterinarians, and others engaged in research, instruction or analysis. This latter class is spoken of as a whole as practitioners. Each of these different classes are charged a different fee for a license. Then, if a physician sells narcotics or deals in them in any way other than in the good faith practice of medicine, he is in fact acting as a retail dealer without a license to do so. The federal government then prosecutes on the basis of the violation of a revenue act.

The penalties for the violation of that revenue act are very severe. They range from a fine up to $2,000 and imprisonment up to fifteen years, or both, to a fine up to $10,000 and imprisonment up to twenty years, or both, and for the imposition of more than one fine or imprisonment, or both, for certain violations.

It is practically impossible for a physician to violate federal narcotic laws over a matter of only a few years without being discovered and arrested. Every bit of narcotics legally imported and manufactured is registered and can be traced directly to the practitioner if it is used by a practitioner, and this can be done with ease. The importer or manufacturer makes his report to the government as to the distribution of the product he obtains. The wholesaler makes a like report regarding the distribution to retailers, and the retailer makes a like report regarding the distribution to practitioners. So, one in Washington can simply run his finger down the names of these various licensed dealers and find where a retailer may be getting an unusual amount of narcotics. Then the retailer produces his record and shows where it is being sold.

Under the law the practitioner must keep a record of his prescriptions, but he need not keep a record where he dispenses narcotics by the direct administration of them to patients he personally attends.

The purpose of the issuing of a prescription or the administration to a patient must be a legitimate medical purpose. The prescription or administration not in the course of professional treatment, but for the purpose of providing the user with narcotics to keep him comfortable by maintaining his customary use is not a prescription or administration within the meaning and intent of the law.

The narcotic law enforcement officers look with disfavor upon any attempt by physicians to treat drug addicts and attempt to cure them of their addiction through tapering-off in the amounts of the prescriptions with ambulatory patients. If an ambulatory patient, seeking what he claims to be treatment for the purpose of tapering off, can get enough physicians to give prescriptions ostensibly for that purpose, he may still be increasing the amount of the narcotics used by increasing the number of physicians on whom he calls, and thereby be strengthening his addiction to the drug. This is a fact so obvious that the courts have regarded a defense to the effect that the doctor was only trying to help him taper off as of little or no value.

THE FAMILY PHYSICIAN IN RELATION TO VOCATIONAL REHABILITATION

FRANK M. HALL, M.D.

INDIANAPOLIS

VOCATIONAL rehabilitation has been a reality in Indiana since March 10, 1921. On that date the Governor of Indiana signed the Acceptance Act—an Act which accepted the terms of the Smith-Fess federal law passed by Congress June 21, 1920. This initiated the use of state and federal funds on a fifty-fifty basis for the restoration of handicapped persons to gainful employment. For twenty-two years thereafter the handicapped in Indiana received for the most part the following types of assistance: (1) GUIDANCE (vocational counseling and guidance for selective job placement, (2) APPLIANCES (artificial legs, arms, braces, hearing aids, eyeglasses), (3) TRAINING (tuition, maintenance for on the job, college, university, trade and correspondence school training.)

Great benefit resulted from this program, but it was realized that the greatest restoration and rehabilitation was not accomplished because no provision was made to reduce or remove the handicap which interfered with the client re-entering remunerative employment. "Training around the handicap" was the accepted practice.

In the last three years a new approach has come about. PHYSICAL RESTORATION (surgical, medical, treatment, hospitalization to remove or reduce physical disability) is now a fundamental phase of vocational rehabilitation. Public Law 113, known as the Barden-LaFollette Act, which became effective over three years ago, provides for a comprehensive physical restoration program. However, if there is reasonable likelihood that medical science can substantially reduce the evil effects of the handicap or remove the handicap entirely as an interference to employment, this service is offered the client first. Disabilities classified as chronic and therefore impossible to substantially reduce within a reasonable time are not acceptable for treatment in accordance with criteria establishing eligibility for service under the Act. The service is not a general medical care program and physical restoration is offered only under four conditions: (1) an individual must have a disability which constitutes an employment handicap, (2) the disability must be relatively stable, (3) the disability must be amenable to treatment, (4) a financial need must exist.

It would seem that a program to enlist handicapped persons in useful occupations, should attain wider acceptance not only by the laymen but, also, by the physicians of our state. Probably the most significant reason why rehabilitation has not received greater emphasis is the fact that its services and benefits are not generally known.

The Indiana State Division of Vocational Rehabilitation is an agency that can produce, through its activities in rehabilitation, a good return on the money spent in restoring the disabled. Very recently in a central Indiana city a rehabilitation counselor was called into a home to assist in restoring a sixteen-year-old son to remunerative employment. The young man had a disability (inguinal hernia) that prevented him from obtaining work. By rehabilitation surgery and job placement of the son, the aged parents were removed from the roster of public welfare assistance. In rehabilitating this young man the state approved and expended the total sum of $217.98, i.e., general medical examination—$5.00; specialist's examination—$10.00; surgeon's fee—$75.00; hospitalization —$127.98. Today, this individual is at work and maintaining himself and parents. This is illustrative of rehabilitation in action.

Sound rehabilitation is based on a complete and adequate medical diagnosis not only for the purpose of determining the client's physical limitations but, also, of evaluating his remaining capabilities. The essential factors in the evaluation of the individual lie in the field of medicine and are left to the judgment of the physician, trained in the function of the human body.

It is the policy of the Indiana Vocational Rehabilitation Division to urge all clients to see their family physician for this initial service. We believe he knows their circumstances, and certainly is a better judge in determining whether a physical disability is a vocational handicap, and if there are possibilities of these handicaps being substantially reduced so that the client may become self-supporting. The free choice of physician is practiced by this Division.

Before starting and establishing physical restoration as a phase of rehabilitation, the State Division of Vocational Rehabilitation asked for the cooperation and approval of the Indiana State Medical Association. As a result, a committee was appointed from its membership to act as the Professional Advisory Committee and cooperate with the agency in an advisory capacity. With the approval of the Committee, the writer of this article was recommended and duly appointed as the first full-time Supervisor of Physical Restoration and Medical Administrative Consultant.

In providing rehabilitation service for those who are entitled to it and in eliminating those who do not meet the requirements, the medical screening is no small job. Without the help and cooperation of the profession in Indiana, as your technical

advisor to Vocational Rehabilitation, I will not be able to hold the program to a safe and sane service.

Space limitations will not permit a comprehensive discussion of the Vocational Rehabilitation Act in its full impact upon the physician. However, as liaison officer between the medical profession and Vocational Rehabilitation, I stand ready to meet any individual or group representing the profession for further discussion.

STATUTES OF INDIANA REGULATING THE PRACTICE OF MEDICINE

STATEWIDE regulation of the practice of medicine began with the Medical Practice Act of 1897, under which a Board of Medical Registration and Examination was created. It contained a "grandfather" clause under which those who had licenses under the preceding law could obtain registration and certification for a license under the new law. The preceding law permitted a license to be granted by the county clerk upon the filing of certain information by the applicant.

Certificates for license are effective throughout the State. They are presented to the clerk of the county in which the physician resides and the clerks still issue the licenses. Except for those obtaining certificates under the "grandfather" clause of the 1897 Act, certificates were granted under the following conditions: (a) upon the submission of a diploma from a recognized school of medicine, or (b) if not graduated from a recognized school, then upon the passing of an examination given by the Board.

The Board at that time consisted of five members, one of whom was required to be a homeopath, one a physio-medical, one an eclectic, and one an allopath, as regular physicians were then designated by homeopaths. No discrimination was permitted for or against any school or system of medicine.

Under the 1899 Act

The 1899 Act eliminated the provision under which one could obtain a license to practice medicine by taking an examination if he had not graduated from a recognized school. It required both graduation from a recognized school and the passing of an examination given by the Board. It clarified some of the provisions of the 1897 Act regarding appeal from the decision of the Board on refusal to grant a license and on revocation of a license after being granted.

Under the 1901 Act

This Act enlarged the definition of the practice of medicine and authorized the issuing of certificates for license to practice osteopathy. Applicants for osteopathic certificates were required to satisfy all the terms and conditions for regular certificates except that they were not required to take an examination in materia medica nor to graduate from schools maintaining standards with respect to materia medica fixed by the Board. Otherwise they were required to conform to the same standards and were issued certificates for license giving them the right to practice osteopathy.

Under the 1905 Act

This act placed an osteopath on the Board as an additional member.

Under the 1909 Act

This Act gave the right and prescribed the procedure by which a physician whose license had been revoked could be restored to his former rights.

Under the 1923 Act

This Act enlarged the scope of practice in which an osteopath might engage by authorizing the granting of certificates for license to "practice osteopathy, surgery and obstetrics, and to administer anesthetics, antiseptics and narcotics." It required schools of osteopathy to comply with the standards required of medical schools except as to materia medica.

Under the 1927 Act

The 1927 Act authorizes the issuing of injunctions against those engaged in the unlawful practice of medicine. It has been effective in the prevention of cultists of various types, who have no license, from continuing in the practice of any form of healing. It does not apply, however, to those who endeavor to prevent or cure disease or suffering "by spiritual means or prayer." It contains a restatement with some modifications of the definition of practice of medicine as it had been defined under previous laws. Many suits have been brought for injunctions against the unlawful practice of medicine under this statute, which have been uniformly successful. The definition of the practice of medicine, and the provisions regarding injunction, read as follows:

"To open an office for such purpose, or to announce to the public in any way a readiness to practice medicine in any county of the state, or to prescribe for, or to give surgical assistance to, or to heal, cure or relieve, or to attempt to heal, cure or relieve those suffering from injury or deformity, or disease of mind or body, or to advertise, or to announce to the public in any manner a readiness or ability to heal, cure or relieve those who may be suffering from injury or deformity, or disease of mind or body, shall be to engage in the practice of medicine within the meaning of this act: Provided, That nothing in this act shall be construed to apply

to or limit in any manner the manufacture, advertisement or sale of proprietary medicines. It shall also be regarded as practicing medicine within the meaning of this act, if any one shall use in connection with his or her name, the words or letters, "Dr.," "Doctor," "Professor," "M. D.," or "Healer," or any other title, word, letter or designation intending to imply or designate him or her as a practitioner of medicine or surgery in any of its branches: Provided, however, That this law shall be construed as applying only to those persons who pretend, claim, assert, or advertise that they diagnose, or in any manner physically treat human disease, injury or deformity, and shall not apply to those who endeavor to prevent or cure disease or suffering by spiritual means or prayer: and, Provided, That this law shall not be construed to prevent any person who now holds or may hereafter obtain and hold a lawful license to practice any profession, calling or vocation from practicing any profession, calling or vocation in accordance with the terms of such license: and, Provided, further, That this act shall not be construed to apply to nonitinerant optometrists who are at this time engaged in, or who may hereafter engage in the practice of optometry in this state, nor to professional or other nurses, nor first aid or pharmacists in their professional duties. The attorney general, prosecuting attorney, the state board of medical registration and examination, or any citizen of any county where any person shall engage in the practice of medicine, as herein defined, without having first obtained a license so to do, may, in accordance with the laws of the State of Indiana governing injunctions, maintain an action in the name of the State of Indiana to enjoin such person from engaging in the practice of medicine, as herein defined, until a license to practice medicine be secured. And any person who has been so enjoined who shall violate such injunction shall be punished for contempt of court: Provided, That such injunction shall not relieve such person so practicing medicine without a license from a criminal prosecution therefor as is now provided by law, but such remedy by injunction shall be in addition to any remedy now provided for the criminal prosecution of such offender. In charging any person in a complaint for injunction or in an affidavit, information or indictment, with a violation of this law by practicing medicine, surgery or obstetrics without a license, it shall be sufficient to charge that he did, upon a certain day and in a certain county, engage in the practice of medicine, he not having any license to so do, without averring any further or more particular facts concerning the same. In case judgment is rendered in favor of the plaintiff in any action brought under the provisions of this act, the court rendering the same shall also render judgment for reasonable attorney's fees in such action in favor of the plaintiff and against the defendant therein, and when collected such fees shall be paid to the attorney or the attorneys of the plaintiff therein, which if paid to the attorney general or any prosecuting attorney shall be additional to any compensation allowed by law."

This Act contained a "grandfather" clause and provision for the appointment of an additional member to the Board. Under the provision for an additional member a chiropractor now serves as a member of the Board. The "grandfather" clause reads as follows:

"Provided, That any chiropractor or practitioner of any other system or method of healing, who is a graduate of a school or college teaching the system or method of healing which he practices, and who was on January 1, 1927, residing in the State of Indiana and practicing chiropractic or any other system or method of healing taught by the school or college of which he is a graduate, shall be given without examination a certificate for a license to practice the system or method of healing in which he has been so engaged."

Under this Act, in a certain sense, the State of Indiana has recognized any form of the practice of medicine whose adherent graduates from a school maintaining the standards prescribed by the State Board and who passes the required examinations. At present the only schools recognized by the Board are regular Class A medical schools and a limited number of schools of osteopathy. No schools of any other kind comply with the standards fixed by the Board. The provision regarding the manner in which irregular practitioners may obtain a license and the qualifications of the additional member of the Board, read as follows:

"That within sixty days after this law goes into effect, it shall be the duty of the governor to appoint an additional member of the state board of medical registration and examination, which board shall thereafter consist of seven members, each of whom shall serve as now provided by law for a term of office of four years, and until his successor shall have been appointed and qualified. The additional member so appointed as well as the successor of such appointee shall be a reputable practitioner of that system or method of healing not now represented on the Indiana state board of medical registration and examination which has the largest numerical representation of practitioners or members in the state, and shall be a graduate of a school or college teaching said system or method. All persons who are now practicing or may hereafter engage in the practice of chiropractic or any other method or system of healing in this state shall be subject in all respects whatsoever to all the provisions of an act entitled, "An act regulating the practice of medicine, surgery and obstetrics, providing for the issuing of licenses to practice, providing for the appointment of a state board of medical registration and examination and defining their duties, defining certain misdemeanors and providing penalties, and repealing all laws in conflict therewith and certain acts therein specified," approved March 8, 1897, and all

acts amendatory thereof and supplemental thereto, except that applicants for license to practice chiropractic or any other system or method of healing in which drugs are not administered and which does not include surgery or obstetrics shall not be required to take an examination in materia medica, surgery and obstetrics."

Under the Act of February 26, 1945, osteopaths were authorized to obtain licenses to practice osteopathy, medicine, surgery and obstetrics; that is, to be granted unlimited licenses. The certificates for such licenses can be issued only to graduates from schools recognized by the Board which comply with the same standards in all subjects as required of regular medical schools. They must also pass the same examinations as regular medical students. This Act also contains a provision under which those osteopaths already licensed may obtain an unlimited certificate by passing an examination in materia medica given by the Board. The Act reads as follows:

"The said board shall grant certificates which shall authorize the proper clerk to issue to the holder thereof a license to practice osteopathy, medicine, surgery and obstetrics. Such certificates shall be issued on the same terms and conditions as certificates to practice medicine, surgery and obstetrics. The holder of such license when issued shall have the right to practice osteopathy, medicine, surgery and obstetrics, without limitation. Any person now licensed to practice osteopathy, surgery and obstetrics, and who desires a license to practice osteopathy, medicine, surgery and obstetrics under the provisions of this act may, upon passing an examination in materia medica as prescribed by the state board of medical registration and examination as provided by law, and upon payment of one dollar, obtain a certificate from the state board of medical registration and examination that he is entitled to the said license possessed by him at the time of the taking effect of this act together with an affidavit that he is the legal possessor of such license and is the person mentioned therein. Such certificates when presented to the clerk of the proper county shall entitle the holder thereof to a license to practice osteopathy, medicine, surgery and obstetrics without limitation, and such license when issued shall entitle the holder thereof to all rights provided in this section."

Under the Act of February 28, 1945

This Act reorganizes the State Board of Medical Registration and Examination into the Board of Medical Registration and Examination of Indiana, and substitutes the latter Board for the former, constituting the latter Board of the following appointees: Five regular physicians graduated from recognized medical colleges with the degree of Doctor of Medicine, and having unlimited licenses; one osteopath licensed to practice osteopathy; and one chiropractor licensed to practice chiropractic.

* * *

The Medical Practice Law in Indiana has been the subject of an attack each year since about 1923 by those who seek to lower the standards of medical practice. The medical profession, in the interests of the general public, should be continuously alert and vigilant against all such efforts, as it has been in the past.

A pamphlet containing all the statute law not in effect in Indiana can be obtained without cost by writing to Board of Medical Registration and Examination of Indiana, 416 K. of P. Building, Indianapolis, Indiana.

THE DISPOSITION OF YOUR ESTATE

PEOPLE who realize that they have accumulated more property than they can use themselves, or who may have the obligation of making provision in the future for their dependents should regard this problem as one that requires the careful consideration of an attorney. It would be impossible in the space of this article to give directions for the making of a will that involves any consideration of future interests. The laws of descent and distribution which operate in the absence of a will are voluminous. They cover every conceivable situation in which a person may die leaving property. There is no situation in which the property would not be disposed of in some manner under the laws of descent and distribution. But whether those laws would be adequate in a particular case requires not only a detailed knowledge of the facts of the case but also of those laws of descent and distribution. If they are not adequate, then a detailed and accurate knowledge of the law of wills is important in the making of a wise distribution of one's estate so it will accomplish the desires of the testator, or maker of the will.

This is a matter of too technical a nature and of too grave an importance that any layman as to the law should attempt to work it out without professional legal assistance.

BEGINNING, CONTINUING AND TERMINATING RELATIONSHIP OF PHYSICIAN AND PATIENT

A PHYSICIAN is under no obligation to accept a patient. Even if the patient is unable to obtain another physician and an emergency exists, the physician, nevertheless, is under no legal obligation to give the person medical care.

But if he accepts the patient, then he has the duty to give the patient treatment and care of the standard for such cases recognized, accepted and approved by the profession in the same or similar localities if he is a general practitioner, or by specialists in his field if he holds himself out as a specialist.

If he neglects his patient by not seeing him often enough, or in any other matter, and the patient suffers injury therefrom he is liable to damages. The physician is required to stay on the case, if it is possible for him to do so, until one of the following things happens: (1) he discharges his patient as cured; (2) he is discharged by his patient; (3) he quits the case as a physician after reasonable notice of his intention to do so; or (4) his patient dies.

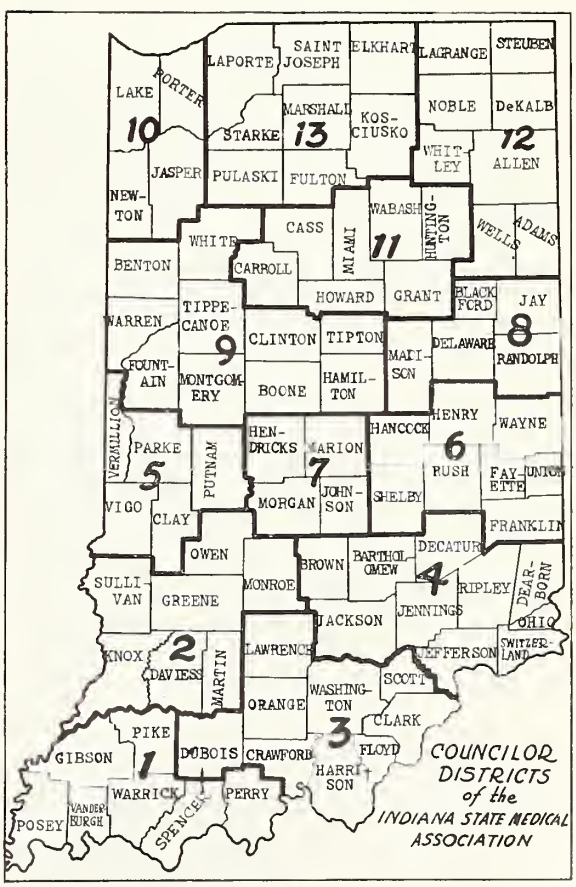
If the physician intends to quit the case he must give to his patient reasonable notice of such intention. Reasonable notice is such notice as gives the patient reasonable opportunity to obtain another physician to continue the treatment if continued treatment is necessary.

If a physician accepts more patients than he can take care of he does so at his peril. If he is not able to give them such treatment as conforms to required standards, he should inform them of that fact in advance. The mere fact that he has too much to do, unless it is explained in advance, ordinarily would not excuse the physician from conforming to the standard of care required, particularly if other physicians would have been available. But, if information regarding that situation is known to the patient and the physician has done the best he could under the circumstances, he would not be liable for neglect even though the patient might have required a greater amount of care than he received.

Of course the patient can discharge the physician without notice, without cause, and at any time he chooses.

Councilors

District	
First	I. C. Barclay, Evansville
Second	James H. Crowder, Sullivan, (Acting)
Third	A. P. Hauss, New Albany
Fourth	Charles F. Overpeck, Greensburg
Fifth	A. M. Mitchell, Terre Haute
Sixth	W. U. Kennedy, New Castle
Seventh	Cyrus J. Clark, Indianapolis
Eighth	E. H. Clauser, Muncie
Ninth	Wemple Dodds, Crawfordsville
Tenth	William H. Howard, Hammond
Eleventh	C. S. Black, Warren
Twelfth	Paul A. Garber, South Whitley
Thirteenth	Alfred Ellison, South Bend



THE LAW PERTAINING TO INTERNS, EXTERNS AND RESIDENTS

THE definitions of interns, externs and residents are determinable by how the words are used in their contracts of employment. The meanings of the words are not definitely fixed in general usage. As the words are used in this article they are defined as follows:

EXTERN—a medical student who is in attendance upon, or is assisting at, a hospital or in hospital work whether performed within the hospital or outside, but who does not reside in the hospital.

INTERN—a physician who works in a hospital or does hospital work and resides within the hospital for which he does the work, and is under the supervision and subject to the orders of other physicians to whom he acts as an assistant and to whom he reports his acts.

RESIDENT—a physician who treats patients receiving hospital care in the hospital or outside of it, and who works generally under the supervision of the physicians for whose patients the resident performs services; the resident generally has supervision of the intern's professional activities in the absence of the physician whose patient receives the services.

Externs

The extern, not being a licensed physician, performs his services under a section of the law which exempts from the medical practice law medical students who practice medicine and surgery under the immediate and direct supervision of a licensed physician. This type of practice can be continued by a medical student for the limited period of two years. While in this limited practice the student is not permitted to open an office or offer to engage in the practice of medicine, surgery or obstetrics. There are no cases in Indiana in which courts have decided the question as to whether or not a student practitioner, or extern, may lawfully receive any pay for his services. As a matter of practice he is not paid for such services, and it seems obvious that if he made any charge he would be engaging in the practice of medicine in violation of the law.

The extern may be liable for his own acts which would constitute malpractice. He is not held to the same standard of skill and ability exacted of the licensed, lawfully practicing physician, so long as he does not engage in the practice of medicine on his own account; but he is required to conform to the standard recognized, approved and accepted as the proper standard for externs rendering the same or like services in the same or similar localities. That is, his work must be as good as the work of the average extern, and if he does a thing which the average extern would not do in the treatment of a patient, or omits to do what the average intern would have done, and the patient suffers as a result, he would be liable in damages.

Interns

An intern, under the above definition, is a licensed, practicing physician. He is not engaged however, in the practice in such a manner as that he assumes the entire responsibility for the treatment of a case, but he is held to a standard of care in doing his work as an intern, which is the standard established by the average skill, ability and performance of interns. In other words he is required to do service in a professional capacity with such responsibilities as pertain to his implied representations as to what his skill and ability is. He does not hold himself out as engaging in the general practice of medicine on his own responsibility. He holds himself out as practicing under limited responsibility, but he must make good in his professional service to the extent to which he holds himself out as possessing skill and ability for that type of practice.

Residents

The liability of the resident for malpractice stands upon the same footing as that of the intern. That is, he must make good to the extent that he holds himself out. He holds himself out as a resident; that is, as one having greater responsibilities than the intern has. So he must conform to the standards recognized, accepted and approved as the standards of residents in the same or similar localities.

Comments on Externs, Interns and Residents

All medical students and physicians in these classes are employees of hospitals. As such they come within the provisions of the Workmen's Compensation Law, and are entitled to receive benefits provided by that law for injuries or occupational diseases suffered by them in the course of their employment.

They are liable for their own acts of malpractice, even though they are employed by a hospital and work under the supervision and direction of others. The general law of negligence is that one should not carelessly and negligently cause injury to others. To do so is a tort, by which is meant a legal wrong. That general principle is a part of the common law. Where externs, interns and residents are involved in acts within their professional duties that general law of negligence has special application, as above stated, to the care and skill appropriate to the services to be rendered.

Since these classes may be liable for negligence in the performance of their services, it is not inappropriate for them to carry malpractice insurance.

CARE OF THE INSANE

HOSPITALS for the insane are located at Evansville, Indianapolis, Logansport, Madison and Richmond; and for the insane criminals at Michigan City. Only those who become insane while serving prison sentences are admitted to the hospital in Michigan City. It is operated in connection with the State Prison and Reformatory. The other hospitals for the insane, while they were created under separate Acts of the Legislature, are now largely managed under one statute which applies to them all. Any insane person residing in the State of Indiana and having a legal settlement in any County of the State is entitled to be maintained and receive medical treatment in the hospital for the insane located in the hospital district in which he resides.

The procedure by which persons are admitted to the hospital is fixed by the statutes. Briefly it is as follows:

1. A reputable citizen of the county makes a statement on a form that may be obtained from the Clerk of the Court.

2. That statement is accompanied by a statement of a reputable physician licensed to practice medicine in the State, who has examined the person alleged to be insane, which statement is in the form also provided by the Clerk of the Court.

3. When these two statements are filed with the Clerk of the Court the Judge of the Court then appoints two medical examiners licensed to practice medicine in the State who examine separately the person alleged to be insane and make their independent reports on forms obtainable from the Clerk.

4. If these statements are adequate and satisfactory to the Judge he then designates the time and place where a hearing will be held to determine whether the person alleged to be insane is insane.

5. At the time of the hearing the person alleged to be insane is represented by the prosecuting attorney. The Judge proceeds with the examination of the case, and if he finds that the person is insane he determines whether the person is a proper patient for treatment in a state hospital for the insane or in a United States government-owned hospital, and whether his being at large is dangerous to the community.

6. If the person alleged to be insane is found to be insane and a veteran of any war and eligible for treatment in a United States hospital, the Judge takes it up with the Veterans Bureau and makes the commitment in accordance with the recommendations of the United States Veterans Bureau.

7. If the person is ordered commited to a hospital but cannot be admitted at once the court directs how the person shall be taken care of until he is admitted, but "under no circumstances shall any insane person be confined in the county jail unless he is found to be dangerous and violent, and then only on the order of the Judge of the Circuit or Superior Court."

Persons dangerous to the community may be put under immediate restraint in the following manner: A complaint under oath is filed with the Judge of the Circuit or Superior Court to the effect that the person alleged to be insane will be dangerous to the community if he remains at large. The Judge thereupon issues a warrant to the sheriff, under which the sheriff arrests the person and brings him at once before the Judge. The Judge conducts a preliminary examination and if it appears to him that the person is dangerous he makes an order for his safe-keeping pending the trial for commitment to an insane asylum. The order for safe-keeping may require the person to be confined in the county jail or in some detention house or otherwise as the Judge may order.

The patient, once admitted to the hospital for the insane, may be discharged therefrom by the superintendent when he deems the patient sufficiently recovered. He may discharge incurable and harmless patients when it is necessary to make room for recent patients, but all dangerous patients must be retained in the hospital. The procedure in this regard is provided by statute and not of general interest to the profession.

The above admissions are involuntary admissions. The law also provides for voluntary admissions of any person suitable for care and treatment in a hospital for the insane who voluntarily makes application therefor and whose mental condition renders him competent to make the application. The application for voluntary admission must be accompanied by the statement of two reputable practicing physicians who are residents of the applicant's county. These statements are on forms provided by the hospital to which admission is sought and generally obtainable at the office of the county clerk.

Free clinics may be maintained by the hospitals for the insane as a part of the hospital service. Admitted to it are "worthy persons, residents of the district, suffering from mental diseases, where examinations, advice and treatment may be given by the hospital medical staff."

Under an old law which has never been repealed insanity inquests may be held before Justices of the Peace, but that practice has discontinued with the coming of better roads which make easily accessible to all the people the courts of the counties in which they reside.

Non-resident insane are taken care of through the State Department of Public Welfare.

Admission to Federally-maintained institutions is governed by a 1945 Act. Under that law, either a physician or a Federal Administrator or the ad-

ministrative head of a mental institution of the state may file a petition in the Circuit or Superior Court alleging facts showing a person to be afflicted with mental illness and to be entitled to care and treatment in a Federal institution. Thereupon the Judge appoints a physician who examines the person and makes a report to the Court. If the report of the physician is that the person is suffering from a mental illness, the Court holds a hearing in which the person is represented by the Prosecuting Attorney. The judge makes an order for his commitment to the Federal institution he finds is appropriate. In the case of a violent person, procedure under this statute is the same as above set forth. Voluntary admission under this Act is the same as above stated.

THE PHYSICIAN AND THE WELFARE ACTS

WHILE the public generally thinks of the Welfare Law as being a federal law, physicians are aware that the only means through which the federal government exerts any influence with respect to the use of funds for welfare purposes is through its grants-in-aid. The state develops a welfare department and if that department satisfies the standards fixed in the federal law, then the federal government provides funds in part for the purpose of carrying out the state welfare department provisions. The activities of the state welfare department are subject to investigation and survey to determine whether or not the states are entitled to continue to receive the federal aid. But the public welfare law, so far as it affects the physician, is the state law.

The state law pertains to various classes of people who may need medical care. A brief statement follows with respect to each class:

Blind Persons. To enable a blind person to receive public welfare assistance he must have an examination by an ophthalmologist or eye specialist who holds the degree of Doctor of Medicine, and has been designated by the County Department and approved by the State Department or who has been designated by the State Department to make such examinations. Where no ophthalmologist or eye, ear, nose, and throat specialist is available, the certificate concerning the applicant's condition may be signed by a duly qualified, licensed and registered optometrist. The certificate of the physician certifies to the diagnosis, prognosis, and visual acuity of the applicant. The state department must adopt reasonable fee schedules for such examinations.

Recipients of assistance must submit to a re-examination of the eyes at least once every three years unless excused therefrom by the state department, and must submit at any other time when required to do so by the county or state department.

Crippled Children. The state department administers the funds for services to crippled children. It cooperates with the State Board of Health and the county departments of public welfare and the Children's Bureau of the United States Department of Labor. In extending and improving the services not only covering the care, but for locating the crippled children, this cooperation extends to other agencies of the state dealing with children.

Crippled children in need of hospitalization may be placed in any public or private hospital selected and approved by the state department, or they may be placed in the James Whitcomb Riley Hospital. When the child is placed in the latter hospital it is under the exclusive jurisdiction of the authorities having charge of that hospital as long as it is a patient therein. The procedure for admission to the James Whitcomb Riley Hospital is as follows:

a. If the County Board of Public Welfare, after examination and upon recommendation of a physician or surgeon having the degree of Doctor of Medicine, is of the opinion that a child suffering from a disease, defect or deformity, could be benefited by treatment in the Riley Hospital; and if the parent, guardian or custodian of the child is financially unable to pay the expenses of such treatment, the County Board, with the written consent of the parent, guardian or custodian, sends a written recommendation to the State Board that the child be placed in the hospital for treatment; and if the State Board approves the recommendation it applies to the authorities having charge of the Riley Hospital for admission.

b. The authorities in charge of the hospital must then admit such child as soon as the available facilities of the hospital are adequate for its treatment.

c. If for any reason it may be deemed necessary, the County Board, upon authorization by the State Board, may file a petition in the Circuit or Superior Court or other court of competent jurisdiction of the county in which the crippled child has its legal settlement, asking the court to commit the child to the hospital for such treatment as may be found necessary, and the court may enter such an order.

All the necessary expenses are paid out of the County Welfare Fund of the County in which the child has its legal settlement. The County then may be reimbursed from Welfare Funds under the control of the State Department.

The physician in attendance is required to report within thirty days of the birth of a child with visible congenital deformity, regarding such deformity, to the State Department. That report of the deformity is used by the State Department

in the performance of its duties under the Welfare Act, but is not open to public inspection nor considered in any way a public record.

There is a Division of Medical Care in the State Department of Public Welfare. It has charge of the supervision of the public benevolent institutions of the State. It also has the duty to establish, maintain, and make available mental health clinics "under psychiatric supervision" for the diagnosis, treatment and prevention of mental diseases, behavior and personality disorders, delinquency, and criminality of children and adults for whom such services are not otherwise available or obtainable because of indigence or other reasons. This Division conducts research in regard to mental health and disseminates information thereon to the public.

In addition to the services of the Welfare Department on behalf of the poor, there is also available the township service afforded through the township trustee as overseer of the poor. The law under which he operates requires that in cases of necessity he promptly provide medical and surgical attendance for all the poor in his township, who are not provided for in public institutions, and see that the medicines prescribed are properly furnished.

WORKMEN'S COMPENSATION ACT

THE Workmen's Compensation Act was designed to protect the working men of the state and to provide recompense for injuries or diseases received during the course of their employment, and to provide them with medical attention necessary to accomplish their rehabilitation.

The Act applies to all classes of employees except casual laborers, farmers or agricultural employees, and domestic servants. These excepted classes come under the provisions of the Act only in the event the employer elects to accept its provisions.

During the first ninety days after an injury it is the duty of the employer to furnish, free of charge, to the injured employee an attending physician for the treatment of his injuries, and in addition the employer must furnish the surgical, hospital and nursing services and supplies as the attending physician or the Industrial Board may deem necessary. The employer may furnish these services and supplies after the expiration of the ninety day period and during the remainder of the time the employee is disabled or impaired by the injury. In event the employee refuses to accept the services and supplies for the additional period, the employee is barred from compensation during the period of his refusal. If an emergency exists or if the employer refuses to furnish the medical services and supplies for the first ninety days, the employee may obtain them himself, and the reasonable cost of the services and supplies shall then be paid by the employer subject to the approval of the Industrial Board.

Should a physician be employed to attend an injured employee by the employer, the physician, of course, collects his fees from the employer. In this situation the employer selects the physician for his employee, and the employee must accept that physician unless he presents reasons satisfactory to the Board for not doing so—in which event the Board may require the employer to furnish another physician. But if the employee refuses to be treated by any physician designated by his employer with the approval of the Board, the employee forfeits his right to compensation. The employee does not have the right of freedom of choice of physician if he retains the right to compensation. If he surrenders the right to compensation, the employee of course may choose his own physician. In event the contract of employment is between the injured employee and the physician the physician may collect from the employee. If the services are rendered during the first ninety days after the injury was sustained and the employer fails to furnish a physician, the employer may be forced to pay the fee subject to the approval of the Industrial Board. In the latter instance claims for fees should be forwarded to the Industrial Board and, at the time of the hearing on the employee's injury and his right to compensation, the fees claimed will be given consideration by the Industrial Board.

The Board, or any of its members, upon its own motion or upon the application of either the employer or employee may appoint a physician or surgeon to make necessary medical examinations of the employee and testify regarding the extent of the injuries to the employee. The physician or surgeon is allowed traveling expenses incident to such treatment and necessary to allow the physician or surgeon to testify in respect thereto, and, in addition is allowed a fee for such services not to exceed ten dollars for each examination, in ordinary cases.

In extraordinary cases the Industrial Board can, and will, allow a fee in excess of ten dollars. The Industrial Board may withhold the approval of the fees of any physician or surgeon until proper reports have been filed. So it seems advisable for all medical men to have available forms upon which they can render reports of services rendered. Forms for claims for fees are available at the Industrial Board which is presently located at 141 South Meridian Street, Indianapolis. They are generally furnished by the compensation insurance carriers.

The State of Indiana has not set up a schedule of fees to be allowed in Industrial Board cases, but will approve fees which are comparable to the average fee charged a person who has a financial status similar to that of the injured employee.

Trusts, Life Insurance, and Annuities

SOME prefer to set up provisions for the care of those for whose care they have a sense of special responsibility, through plans which become effective within their own lifetime. Life insurance companies have worked out varieties of plans for the protection of one during his own lifetime and for the care and support of those who survive him.

All these plans, so far as they involve future interests or the allocation of funds in the nature of trusts or for the provision of annuities, involve not only a knowledge of life insurance but of investments, and also of the law regarding estates and future interests, for their most likely possibility of satisfactory solution. But even then it must be admitted, as Burns said, that

"The best laid schemes o' mice and men
Gang aft a-gley."

Problems of this kind cannot be solved by any rule of thumb that will apply in all cases. This again, like the practice of medicine, is in the field of professional training. And, like in the practice of medicine, the best-trained may make mistakes, but the chance against making mistakes is better with the trained professional person than with the untrained layman. So counsel of the lawyer, the insurance man, and the investment man should be sought as to these matters. This may sound like an expensive program. Ordinarily it is not. There is some satisfaction, too, in feeling that what has been gathered together by one's efforts will be used to accomplish the purposes he desires, and that knowledge may still be a stimulus to his activity and an added pleasure from his continued achievements.

Sterilization

THERE is no statutory law regarding sterilization in the State of Indiana except what pertains to defectives, who are in state institutions or may be committed to state institutions. It applies to any mentally incompetent person who is "the probable potential parent of mentally incompetent or socially inadequate offspring likewise afflicted." The procedure in connection with such cases is provided by a statute, but since it is not of general interest it will not be summarized in this article.

But with regard to voluntary sterilization of those who are of sound mind, the question assumes a different form. There is a criminal statute on mayhem, which reads as follows:

> "Whoever violently and unlawfully deprives another of the use of any bodily member . . . is guilty of a simple mayhem, and on conviction shall be fined not less than $5.00 nor more than $2,000.00, and shall be imprisoned in the County Jail not less than twenty days nor more than six months."

The statute does not help much in the determination of the question under consideration. The question is whether sterilization performed at the consent and request of another constitutes an unlawful deprivation of another of the use of any bodily member. There is a case decided by the Indiana Supreme Court to the effect that a person cannot hold a physician liable for performing unreasonable surgery where he has requested the physician to do so. The general language of that opinion supports the conclusion that voluntary sterilization could be performed without the violation of any law whatever.

The sterilization laws pertaining to inmates of state institutions who are mentally defective and fall within the classification above described, is constitutional. Since that law has been universally regarded by the courts as constitutional, it follows that voluntary sterilization would be lawful for the reason that the state could not treat its wards with severity or cruelty or engage in maiming them or committing mayhem on them. Therefore, if sterilization were to constitute any form of mutilation or injury to the body that could consitute mayhem, the sterilization law regarding inmates of state institutions could not be sustained. Since it is sustained, it follows that voluntary sterilization is lawful. The consent to sterilization should be in writing, signed by the patient, for the mere purpose of defense against a false charge that might be made by the patient that he had not given his consent, if he later changed his mind about sterilization and regretted having the operation performed.

What has been said here applies to men and women alike. Under the statutes that have emancipated woman, it would not seem necessary for a married woman to have her husband's consent, nor for a married man to have his wife's consent. It would be advisable to have the consent of both, in order to avoid being the person who might be sued in some case in which the validity of this opinion would be tested in the courts.

Laws Regarding Abortion

THE statute regarding the crime of abortion in Indiana reads as follows:

> "Whoever prescribes or administers to any pregnant woman, or to any woman who he supposes to be pregnant, any drug, medicine or substance whatever, with intent thereby to procure the miscarriage of such woman, or, with like intent, uses or suggests, directs or advises, the use of any instrument or means whatever, unless such miscarriage is necessary to preserve her life, shall, on conviction, if the woman miscarries, or dies in consequence thereof, be fined not less than $100 nor more than $1,000, and be imprisoned in the state prison not less than three years nor more than fourteen years."

Special attention is invited to the fact that criminal abortion may occur where the woman involved is not pregnant but where, on the supposition that she is, something is done to induce a miscarriage, and the woman dies in consequence thereof. The crime is complete whether the woman is pregnant or not, under such conditions. If she is pregnant, then either her miscarriage or death as a result of an attempt to produce the miscarriage is the complete crime.

Under this statute there is only one type of lawful abortion, or attempt to produce abortion. That is where, in good faith, the physician believes that a miscarriage is necessary to preserve the life of a woman whom he believes to be pregnant. Of course, if she is not pregnant, and the doctor under these conditions attempts to bring about a miscarriage and she dies, there is no liability on the part of the doctor, if he acted in good faith and with the skill and ability that would conform to the standards of practice accepted, recognized, and approved, in the same or like communities; or, if the physician is a specialist, to the standard of specialists in that field.

The difficulty in the administration of this law lies in the determination of what is necessary to preserve the life of the woman, and in exactly what may be meant by that language. If the pregnancy, when permitted to be carried to its normal termination, would result in the shortening of the life of the woman, then it should reasonably be held that the abortion was justifiable, even though the experience of childbirth would not itself have caused the death. Whatever is itself the actual cause of the shortening of the life of a human being is the cause of his death. So if a woman who is pregnant may be suffering from some disease whose course might be accelerated so that death would occur earlier because of childbirth than it would otherwise occur, the abortion would not be unlawful. Under such circumstances the woman would be guilty of no crime in seeking to obtain an abortion. She is guilty, however, of crime, where an abortion is not necessary to save her life or the life of the child and she seeks to obtain the means of producing a miscarriage or submits to any form of treatment for that purpose.

To be absolutely certain, or at least as certain as human precaution could make it, that a physician might not be subjected to difficulties later on account of an abortion, he should have consultation with other physicians and ample evidence to prove that the abortion was actually necessary.

Regarding Birth and Death Certificates

Funeral directors or persons in charge of interment must file with the health officers having jurisdiction a certificate of death and receive a permit prior to the disposition of the body. They have the duty of obtaining and entering on the certificate such personal data as may be required by the State Board of Health from the person best qualified to supply that data. The funeral director presents the certificate of death to the physician last in attendance upon the deceased "who shall certify the cause of death." If the death occurred without medical attendance or the physician fails to sign the death certificate the health officer must investigate and certify the cause of death on the basis of information obtained from persons having knowledge of the facts. If the circumstances suggest that the death was caused by other than natural causes the health officer refers the case to the coroner for investigation.

Births, stillbirths and deaths must be reported upon forms furnished by the State Board of Health. A report of birth must be filed within five days of the birth, but the report may be accepted if it is filed within four years, provided the health officer is given good reason why such record was not filed within the time prescribed. If it is not filed within four years, then a special form of birth certificate, called a "delayed certificate of birth," may be issued. Application for delayed registration is made to the Department of Vital Statistics of the Indiana State Board of Health.

Disclosure of illegitimacy of birth, or of information from which it can be ascertained, may be made only upon a court order except as such disclosure by the physician may be required by the form of the report he must use.

A stillbirth is reported on a special form which serves both as a birth and a death report. Stillbirth means a birth after twenty weeks gestation which is not a live birth. A live birth means the birth of a child who shows evidence of life after the child is entirely outside of the mother.

The State Board of Health may adopt rules and regulations concerning the recording of births and deaths. The records and files of the Bureau of Vital Statistics are confidential and may not be inspected or certified copies obtained unless the applicant therefor has a direct interest in the matter recorded and the information contained is necessary for the determination of personal or property rights. The decision of the registrar is reviewable by the State Board of Health or by a court. The Board may permit the use of data contained in vital statistics for research purposes only, but no identifying use thereof shall be made.

It has been suggested that the form in which the physician's report of a death is made might be separated from the rest of the form of the death certificate which the physician does not fill, and that this might bring about more accurate reporting of the causes of death—which would be of value in relation to the use of vital statistics for medical research.

The penalty for the violation of the duties imposed upon a physician regarding the making of reports and the signing of certificates, by the law or the rules and regulations of the Board of Health, is a fine of not more than ten dollars.

LEGAL ASPECTS OF AUTOPSIES

AUTOPSIES may be performed without the consent of those having the right of burial only where they are performed in proper coroners' cases. So the discussion of autopsies will come under two headings.

Autopsies Under Employment of Coroners

The duty of a coroner is stated in this language: "Every coroner, as soon as he shall be notified that the dead body of any person, supposed to have come to his death by violence or casualty, is within his county, shall immediately proceed to inquire, upon view of the body, how and in what manner he came to his death." (Burns 1945 Supp., Section 49-2904.)

The mere fact that the cause of a death may not be known does not make of that death a coroner's case. It must be a death supposed to have resulted from violence or casualty. And the extent of the inquiry of the coroner is only as to how and in what manner the death supposed to have resulted from violence or casualty was caused. Further than that, the coroner has no duty to perform in relation to the death, except such ancillary ones as caring for the property upon the body and making photographs to aid in determining the cause of death.

The function of the coroner is to aid in the enforcement of laws against homicide. In this connection the coroner may employ a surgeon or physician to make a post-mortem examination. (Burns 1933, Section 49-2907.)

It would seem to be the law that a physician employed to make a post-mortem examination under these conditions could not be held liable for making a post-mortem examination where it was not a proper coroner's case. The physician should certainly have the right to rely upon the coroner as a public official to act in good faith and not hold a post-mortem examination except where the cause of the death was unknown but was supposed to have resulted from violence or casualty.

Casualty in this connection generally means accident, while violence means force or other means through which death ensues other than from natural causes.

It would be the part of wisdom for physicians and coroners in some instances to err on the side of caution by avoiding post-mortems unless there is some reasonable ground on which to suppose the death to have resulted from violence or casualty, as only such deaths are within the jurisdiction of the coroner.

Autopsies By Consent

There are no statutes definitely establishing right of burial. That is a right recognized and enforceable in Indiana under the common law. The bodies of the dead belong to the surviving relatives who have the duty to make proper disposition of it. That right comes to the surviving relatives in the order of the right of inheritance of property. But the body cannot be disposed of by sale. A person cannot even make a valid and binding contract to sell his own body, although he may, within certain limits, make provisions for its disposal after his death. The right of burial belongs to the surviving spouse, and after that to the next of kin.

An unauthorized autopsy is a tort giving a right to an action for damages, although there are some cases in other states holding that a physician who performs an autopsy in order to make a proper death return is not liable for making an autopsy only to that extent, even without the consent of those having the right of burial. There are no such cases decided either way in Indiana. The safer plan is to avoid raising that question in one's own practice by obtaining a proper consent even where the only thing done to the body is to make such post-mortem examination as may be necessary to ascertain the cause of death.

AN OPPORTUNITY TO HEAR DOCTOR LULL

Members of the Indiana State Medical Association are invited by the Committee on Secretaries' Conference to attend its meeting Sunday, January 12, at the Claypool Hotel, Indianapolis.

The program begins at 1:30 p.m. and concludes with a dinner at 6 o'clock. Tickets for the dinner are $3 each. Reservations should be made at the headquarters office of the association not later than January 11.

Dr. George F. Lull, secretary and general manager of the American Medical Association, and Dr. Floyd T. Romberger, president of the state association, will be dinner speakers. Doctor Lull, who as a major general served brilliantly in World War II, will talk on "American Medicine Looks to the Future."

Dr. J. S. DeTar of Milan, Michigan, chairman of the Public Relations Committee of the Michigan State Medical Society, will speak on "Public Relations" in the afternoon.

The complete program is published on page 63 in this issue.

FEDERAL INCOME TAX AND THE MEDICAL PROFESSION

F. SHIRLEY WILCOX

COLLECTOR OF INTERNAL REVENUE

INDIANAPOLIS

TAX RATES reached their peak in 1944 and 1945. Beginning with 1946 they are starting downward. The laws affecting the income and deductions for the year 1946 are substantially the same as for the year 1945. However, the Revenue Act of 1945, the second major tax bill enacted during 1945, is primarily a tax reduction measure for 1946, giving lower taxes for the calendar year 1946 and for a pro-rata part of fiscal years 1945-1946.

Under this Act individuals are allowed the same exemptions from normal tax as they have been allowed for surtax. The surtax exemptions are unchanged from the previous law. Exemptions allowable for 1946 for both normal and surtax are:

(A) An exemption of $500 for the taxpayer;

(B) An exemption of $500 for the spouse of the taxpayer if—

(i) a joint return is made by the taxpayer and his spouse under section 51, in which case the exemption of the spouse is under subparagraph (A) and this subparagraph shall be only $1,000 in the aggregate; or

(ii) a separate return is made by the taxpayer and his spouse has no gross income for the calendar year in which the taxable year of the taxpayer begins and is not the dependent of another taxpayer;

(C) An exemption of $500 for each dependent whose gross income for the calendar year in which the taxable year of the taxpayer begins is less than $500, except that if such dependent is married the exemption in respect of such dependent shall not be allowed if such dependent has made a joint return with the other spouse under section 51 for a taxable year beginning in such calendar year.

(2) DETERMINATION OF STATUS—The determination of whether an individual is married shall be made as of the last day of the taxable year, unless his spouse dies during the taxable year, in which case such determination shall be made as of the date of his spouse's death.

(3) DEFINITION OF DEPENDENT—As used in this chapter the term "dependent" means any of the following persons over half of whose support, for the calendar year in which the taxable year of the taxpayer begins, was received from the taxpayer:

(A) a son or daughter of the taxpayer, or a descendant of either;

(B) a stepson or stepdaughter of the taxpayer;

(C) a brother, sister, stepbrother, or stepsister of the taxpayer;

(D) the father or mother of the taxpayer, or an ancestor of either;

(E) a stepfather or stepmother of the taxpayer;

(F) a son or daughter of a brother or sister of the taxpayer;

(G) a brother or sister of the father or mother of the taxpayer;

(H) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer.

As used in this paragraph, the terms "brother" and "sister" include a brother or sister by the half-blood. For the purpose of determining whether any of the foregoing relationships exist, a legally-adopted child of a person shall be considered a child of such person by blood. The term "dependent" does not include any individual who is a citizen or subject of a foreign country unless such individual is a resident of the United States or of a country contiguous to the United States.

Although the credits are increased to correspond with credits allowed for the purpose of surtax, the normal tax rate of 3 per cent of the net income in excess of the credits against net income is retained as in prior law. However, there is a reduction in the rates of surtax. The rates of surtax on individual's income is reduced by three percentage points in each of the surtax net income brackets. The rate on the first $2,000 of surtax net income is 17 per cent instead of the previous 20 per cent. The rate on the highest bracket, surtax net income over $200,000, is 88 per cent instead of 91 per cent.

In addition to the three percentage point reduction in each surtax bracket there is a deduction by 5 per cent of the total tentative surtax and normal tax. Form 1040 for the year 1946 is so constructed to provide for this computation. With this exception the Form 1040 for the year 1946 is practically the same as for last year. There is, however, space provided for entering separately income from dividends and interest income on the new Form 1040. Dividends are to be reported in Line 3, Page 1, and interest, including interest from Government obligations unless wholly exempt, is to be reported in Line 4, Page 1.

The statutory net profit from the medical profession is determined by completing Schedule C of Form 1040 for the year 1946. A written record of receipts and expenditures is highly important to an individual with income from a profession. It is intended that a taxpayer's regular accounts, files of receipts, and usual records shall be sufficient for filing income tax returns, provided that actual and complete information is available and

the taxpayer is prepared to prove the essential reality of claims or statements made.

Expenses deductible in arriving at the net profit, in Line 22, Schedule C, are the normal costs of producing the income. Such expenses must be distinguished from those incurred for the convenience, comfort, or economy of the individual pursuing the profession, or in the nature of loans, gifts, capital investments, and the like. The distinction lies in the purpose and nature of the payment rather than in any account in which it may be charged. Business expenses may include salaries and wages paid, interest on business indebtedness, taxes on business and business property (but not Indiana state gross income tax), depreciation, rents, repairs, and other expenses. Other includable items are commissions, supplies, advertising and insurance payments for one year.

In the case of a professional man, maintenance and repair expenses of an automobile used for professional purposes (but only that portion of the expenses applicable to the professional use) are allowable as well as membership in professional societies, subscriptions to professional journals, current magazines used in the reception room, and fees paid to other professional men for professional assistance.

If a professional man uses his residence as office and home, he may deduct the expense applicable to that part used for professional purposes.

Expenses not deductible include the cost of books and the cost of instruments and equipment having a useful life longer than one year (these are regarded as capital items on which depreciation may be allowable) and membership dues in a purely social club.

The cost of incidental repairs is deductible, provided the property account is not increased by such expenditures, but repairs in the nature of replacements, betterments, and improvements are regarded as capital expenditures and are not deductible.

If physician has other income, such income should be reported on the applicable schedules found on Page 2 of the return, namely: (A) Income from Annuities or Pensions; (B) Income from Rents and Royalties; (D) Gains and Losses from Sales or Exchanges of Capital Assets, et cetera; (E) Income from Partnerships, Estates and Trusts, and other sources.

If a physician has income from a farm, the net farm profit is determined by itemizing the farm income and deductions on Form 1040F in the same manner as in previous years. The net farm profit as determined on Form 1040F may be properly indicated in Schedule E under "Other sources." Form 1040F should be attached to Form 1040 when filing. Total income as listed on Page 2 should be entered in Line 5, Page 1, of the Form 1040.

Physicians receiving compensation for personal services subject to the withholding tax should not include such compensation in his total income in Schedule C, but should indicate the amount of such compensation in Item 2, Page 1, of the return.

The adjusted gross income for the year 1946 is the amount shown in Line 6, Page 1. The individuals whose adjusted gross income is less than $5,000 will be able to determine their tax from the optional tax table on Form 1040. The amount of tax on the tax table allows for personal deductions, such as contributions, interest paid on personal indebtedness, and personal taxes of approximately 10 per cent of the adjusted gross income.

Taxpayers who are not permitted to use the tax table because their adjusted gross income is $5,000 or more may take a standard deduction of $500 in lieu of listing the actual items of deduction. Any taxpayer who elects to compute his tax may itemize his various non-business deductions and credits much the same as for previous years. This would be advantageous only for those whose deductions are in excess of 10 per cent of their adjusted gross income.

If the final Form 1040 for the year 1946 is filed on or before January 15, 1947, and the tax as shown due is paid in full, the taxpayer is relieved of filing an amended declaration of estimated income tax, which might otherwise be required on that date. If there has been no material change in the estimated income tax, and the fourth installment of the estimated tax for the year 1946 is paid by January 15, 1947, the due date for filing the final 1946 federal income tax return is March 15, 1947. The payment accompanying a final return must cover the full amount not previously paid in connection with the declaration of estimated tax or through withholding.

On or before March 15, 1947, an individual deriving his income from the medical profession is required to file a declaration of estimated income tax for the year 1947 and pay at least one-fourth of the estimated tax.

It is suggested that if any specific question arises relative to the determination of the federal income tax you communicate with the Collector's Office in Indianapolis, or contact the nearest zone or division office in Indiana.

USE THE JOURNAL LIBRARY

Many valuable medical books are sent to THE JOURNAL by publishers and authors for review. These books are placed in a library where members of the state medical association are welcome to use them. If you want to do some reading, come to 1017 Hume Mansur Building, Indianapolis, and pick out a recent book on some medical subject.

THE STATE INHERITANCE TAX

GEORGE F. DICKMAN

INDIANA INHERITANCE TAX ADMINISTRATOR

INDIANAPOLIS

THE so-called Inheritance Tax Law in Indiana was first enacted in this state in 1913. It is more than a tax on inheritance. It is also a tax upon all transfers, in trust or otherwise, of a decedent, under conditions and subject to the exemptions and limitations therein described. In other words, it is a tax upon all the property transferred by a decedent either by will, the laws of descent of the State of Indiana; deeds made without a full and bona fide consideration which are donative in character; conveyances and gifts made in contemplation of death; revokable trusts; trusts, conveyances and gifts in which the trustor, grantor, or donor retain or reserve to himself any income or interest in the property transferred, or gifts and grants intended to take effect in possession or enjoyment at or after death of the transferror.

The law does not tax real estate held by the entireties nor pure life insurance particularly where insured passed a physical examination to procure the policy and has named a particular person as the beneficiary instead of his estate. Most annuity contracts are subject to tax since they are not, strictly speaking, life insurance and are in the nature of gifts to a beneficiary intended to take effect in possession and enjoyment at or after death.

Property held in the joint names of the decedent and another or others, either jointly or to the survivor, or payable upon death to the other named person or persons is subject to transfer tax against the surviving joint owner upon the death of one person, upon the theory that it is a gift intended to take effect in possession and enjoyment at or after death, excepting therefrom any part of the value of the jointly-owned property which the survivor can prove was contributed by the survivor toward the original purchase price thereof.

The beneficiaries of a decedent's estate ordinarily are entitled to deduct from the gross estate all of the decedent's debts, funeral expense and reasonable costs of administration. However, one must keep in mind that if he has arranged his business affairs in such a manner that he has in fact disposed of all of this property prior to death, for example, owning real estate by entireties, conveying real estate prior to death to the natural object of his bounty without a bona fide consideration, jointly-owned property payable to a survivor, then the above deductions are not allowable for there would be no estate of the decedent to administer upon, nor out of which to deduct debts and expenses. If one plans on disposing of his property prior to death, as above pointed out, he should at least leave enough property in his own name to pay his debts and funeral expenses in order to have the advantage of the deductions allowed by law.

The beneficiaries of a decedent's estate are divided into three classes for the purpose of allowing personal exemptions, viz.: Class A, which includes wife, husband, lineal descendants, and lineal ancestors, mutually-acknowledged child, or adopted child. The widow has an exemption of $15,000, and each of the others in Class A have an exemption of $2,000, except children under eighteen years, who have a $5,000 exemption. Class B includes brother, sister, descendant of brother or sister, wife or widow of son, husband of daughter. Each in Class B have an exemption of $500. Class C includes all others, with an exemption of $100. The rate of tax for those in Class A is 1 per cent on the first $25,000 and 2 per cent on next $25,000 et cetera. The rate on Class B is 5 per cent on the first $100,000. The rate on Class C is 7 per cent on the first $100,000. The above-mentioned exemptions must be taken out of the first block of $25,000 transferred to each person.

There are a number of other detailed provisions in the inheritance tax law, but the foregoing will give you a brief and general idea of the nature of the law. If there should be any question arise in regard to the law, this department is always happy and willing to give any additional information desired.

INDIANA BROADCAST JANUARY 25

Don't forget to tune your radio to the "Doctors Now and Then" broadcast at 3 o'clock Saturday afternoon, January 25, 1947, when the first cholecystotomy performed by Dr. John S. Bobbs, of Indianapolis, will be dramatized. The program will be carried by more than 125 NBC stations. Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, will speak for a few minutes. The American Medical Association is sponsoring twenty-six such programs as a part of its centennial celebration.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

BETTY MALINKA

INDIANA REPRESENTATIVE

NOTE: The National Foundation for Infantile Paralysis is one of the country's newer national health organizations supported by the public. Organized only eight years ago, the foundation now has chapters in each of Indiana's 92 counties—and more than 2,700 in the United States. Unlike the more common diseases, poliomyelitis confronts the average doctor at widely separated times except in areas where severe outbreaks occur. Therefore, many in the medical profession have not had occasion to learn the part the Foundation, and particularly its local chapters, can and will perform to assist patient and physician when polio strikes. This article by Miss Betty Malinka, Indiana representative of the National Foundation, tells the story.

The National Foundation for Infantile Paralysis, working through the medical profession, is sponsoring the most widespread attack in history on a single disease.

The front lines of this offensive extend to every city, village and rural area where poliomyelitis strikes. Here the local chapters of the Foundation (including one in each of Indiana's 92 counties) stand ready to aid victims of polio. The chapters are supported in event of severe outbreaks, or in any case where local chapter funds are exhausted, by a special nation-wide epidemic fund of the national organization.

Meanwhile, behind these front lines, the Foundation supports a program of professional training of doctors, nurses and volunteers aimed at providing better and better care for those who suffer from the disease. Special equipment for hospitals also is provided.

Still further back, in the laboratories of medical institutions throughout the country, the Foundation finances year-round research which it is hoped someday will banish the fear of this disease.

To carry on its fight against infantile paralysis, the Foundation works through groups at two major levels—the national organization and the local county chapters. The state office of the Foundation acts as a coordinating agency between the local chapters and the national office and serves as advisor and assistant to the local units made up of volunteer citizens.

Two field representatives of the National Foundation service the chapters in Indiana. They are William Styring, Jr., in the southern section of the state, and Miss Betty Malinka, in the northern section.

Funds to finance the anti-polio program are raised by the county chapters during the last half of January each year, with the appeal reaching its climax on January 30, birthday of the late President Roosevelt, founder of the Foundation. The January, 1947, "March of Dimes" campaign is under the state chairmanship of Dean H. Mitchell, of Hammond, with a committee composed of Governor Ralph F. Gates, the president and secretary of the Indiana State Medical Association, and representatives of several labor, business and women's organizations.

Half of all funds raised is retained by each local chapter. The remainder goes to finance the nation-wide activities of the Foundation.

Work of the County Chapters.

The "grass roots" of the National Foundation are in the county chapters. Here is where individual aid is rendered to polio victims. Here is where the practicing physician comes into contact with the organization. The local chapter chairman or any member of the chapter will welcome inquiries by any doctor as to the financial or other assistance available for patients or local medical institutions.

A "normal procedure" where the doctor does not take the initiative is as follows:

Copies of reports of onset of polio made by doctors to the county health officer and forwarded to the State Board of Health are regularly sent by the State Board to the state office of the Foundation, at 614 Board of Trade Building, Indianapolis;

The local chapter is advised by the state office of the Foundation as to the name of the patient, address and other information;

The local chapter contacts the County Health Officer for further information;

If the County Welfare Department is servicing the case the ordinary procedure is not disturbed, but the department is advised that the chapter will bear costs involved, thus freeing the Welfare Department's tax-raised funds for other health services.

If the case is not being handled through the Welfare Department the doctor is contacted to determine what assistance the chapter can render, and if the doctor recommends, the family of the patient is interviewed. (Local chapters are instructed to interpret a family's "need" for financial aid liberally; that is, it is not the intention that any family be required to reduce its normal standard of living in order to provide the best medical and hospital care. For example, it should not be necessary to mortgage a home to finance a protracted case, or to forego sending one child to college because another has contracted polio. The onset of polio in itself is deemed a sufficient burden.)

The chapter will assist in the medical rehabilitation of old as well as new cases.

May Purchase Hospital Equipment.

In addition to rendering aid to individual patients the local chapters also are authorized to, and frequently do, provide respirators, therapeutic equipment, and other apparatus to local or nearby hospitals for the treatment of polio. This equipment is purchased at the request of, or with the advice of, doctors using the hospital.

In times of emergency, Indiana chapters finance the employment of specialized hospital personnel needed for polio patients. Often these persons are obtained through national headquarters of the Foundation, which maintains a directory of such specialists. The chapters and the National Foundation also finance the training of existing qualified hospital personnel in treatment of infantile paralysis.

Wherever possible, in cooperation with state and county rehabilitation agencies, the chapters assist handicapped polios to be self-sustaining.

At the present time the chapters are helping to provide funds for the Study of Child Health Services being carried on in Indiana under the direction of Dr. E. R. Carlo, looking toward the development of sound plans for better and more evenly-distributed medical and health services for children, sponsored nationally by the American Academy of Pediatrics.

Epidemic Funds at New High

Up to November first nearly $4,000,000 had been expended by the National Foundation this year for aid in areas where infantile paralysis struck in epidemic proportions. More than $1,000,000 has been supplied in Minnesota alone. These sums are in addition to $7,500,000 allocated in the past year for the research and specialist-training programs. The total number of cases reported in the United States soared to more than 23,000, making this the second worst year in history, surpassed only by 1916. In Indiana the number of reported cases up to November thirtieth was 422, or 107 per cent above the same period last year.

In a number of cases poliomyelitis is not the greatest threat to our national health. But in the severity of the disease—which leaves many cripples in its wake each year—polio constitutes an important national menace.

The National Foundation, its Indiana state office, and the local chapters are pledged to an all-out offensive against this menace—through research, education, provision of the best possible hospital equipment, and aid to individuals—until polio is licked.

Doctor, we are at your service.

MEDICAL AND HOSPITAL CARE UNDER THE VETERANS ADMINISTRATION

THE medical profession of the State of Indiana is daily becoming more conscious of the medical needs of the returning veteran.

In treating the veteran there are, of course, two approaches to the problem. The veteran has been advised by officials, at the discharge center before having left the military service, of certain things from a medical point of view to which he was entitled through the facilities of the Veterans Administration. Just what these entitlements are have been a problem, not only to the veteran, but to his family physician, in spite of explanations given him by the military. An attempt should be made to clarify for the profession, in a simplified manner, the services of a medical nature that the veteran may obtain through the facilities of the VA.

The veteran entitlements, medically, may be divided into two major classes. These are the two general services that are granted the veteran under existing laws governing Veteran Administration activities. The first is the veteran's entitlement to hospitalization in a Veterans Administration Hospital for any medical condition, whether service-connected or not, that warrants hospital treatment to accomplish improvement or cure. The veteran's ticket of admission in this case is his honorable discharge from a period of war services.

The procedure to be taken by the practitioner of medicine in an emergency is to place a call with the clinical director of the nearest Veterans Administration Hospital, or the officer of the day of that hospital at night, and ask for a bed for the veteran. The hospital authority contacted should be advised on the following points: first, the veteran's name and address; second, his diagnosis, either absolute or tentative, as was made by you; and, finally, how the veteran can travel and if reimbursement is desired for that traveling. This will assure you and your patient that the veteran will be given due medical consideration on arrival and, if admitted as an emergency, that the expense he has incurred for his travel from his home to the hospital will be paid by the Veterans Administration.

The second general item to which the veteran is entitled, medically, is that of out-patient treatment for a service-connected disability. Much confusion exists in the minds of the veterans and in the minds of the physicians as to the meaning of the term "service-connected." This term is very frequently confused with the term "service-incurred." By "service-connection" is meant that the disability that the veteran suffered in service has been rated by the Rating Board of the Adjudication Service of the Veterans Admin-

istration and declared legally to be service-connected. Such a rating has been accomplished on the majority of the veterans now discharged.

The veteran, at the time of his dismissal from military service, was given an opportunity to file a claim in which he stated, in his own words, the facts concerning any and all injuries or diseases that he suffered while a member of the military service. It is upon this claim and the statements contained thereon and the veteran's military record that service-connection is established.

If service-connection is granted by the Veterans Administration, after a due process of rating, the family physician, as a participant medical examiner of the Veterans Administration, may be authorized to treat this veteran at the veteran's home or in his office. The condition does not have to be medically emergent in order to secure treatment, nor does it have to be of such a nature that hospitalization is indicated. All that the doctor has to show in a service-connected case is that the veteran needs medical treatment to benefit his service-connected condition, and he will be given authority to treat this veteran on an out-patient basis.

It would not be well to conclude this discussion without mentioning those cases wherein presumptive service-connection may be considered. Presumptive service-connection, in simplicity, means that the veteran has suffered a disease or injury while in the military service and that he can present evidence in the form of a sworn statement that he was treated for this condition in service. Then he will be considered for out-patient treatment on the same basis as though he were already service-connected, provided this treatment is requested within two years from the day of discharge.

The important factors for the doctor with the veteran patient to ascertain are: first, how long has the veteran been out of service? If he has been out of service less than two years, the next question that logically follows is, was he treated for this condition while in military service? If the answer to both of these questions is in the affirmative, the doctor can, by contacting a Veterans Administration regional office, secure authority to treat him on an out-patient basis, just as though he had already been rated and the condition declared to be service-connected.

There is one other factor that should be considered by the private physician who is participating in the designated examiner plan of the Indiana State Medical Association. In those cases that present themselves to the doctor, which have no service connection, were not treated for the disability in service, have been out of service longer than two years, and do not have a condition that needs hospital treatment to cure—they must be considered in the same light as any private patient who might enter their office in search of medical aid. As a private patient, and having failed to meet any of the conditions under which

When hospital treatment is desired as an emergency for veterans residing in: Lake, Porter, La Porte, Starke, Marshall, St. Joseph or Elkhart counties, the Clinical Director of the hospital at Hines, Illinois, should be called.

When hospital treatment is desired as an emergency for veterans residing in: Floyd, Harrison, Crawford, Perry, Orange, Washington, Clark, Jefferson, and Scott counties, the call should be directed to the Clinical Director of the VA Hospital at Louisville (Nichols General VA Hospital).

When hospital treatment is desired as an emergency for veterans residing in: Gibson, Posey, Vanderburgh, Warrick, Spencer counties, the call should be directed to the VA Hospital, Marion, Illinois, for the attention of the Clinical Director.

Residents of Wayne County are directed for emergency hospital treatment to the hospital at Dayton, Ohio.

Calls should be placed for the Clinical Director on working days, and for the Officer of the Day after hours and on Saturday, Sunday and holidays.

When a call is placed, give the name and address of the veteran, your diagnosis, and how the veteran can travel. The last is very important.

For counties other than those listed above in the State of Indiana, calls for emergency hospitalization may be directed to the Veterans Administration Hospital, 2601 Cold Spring Road, Indianapolis, Indiana, telephone Talbot 1521, Extension 55, during working hours, and Extension 50 after 4:30 on Saturdays, Sundays and holidays; or The Veterans Administration Billings Hospital, Fort Benjamin Harrison, Indiana, Cherry 0500. Beth of the above are general medical hospitals.

For all neuropsychiatric cases in the State of Indiana, calls for emergency hospitalization should be directed to Doctor Post, Clinical Director, Veterans Administration Hospital, Marion, Indiana. This hospital should be called only if the veteran is willing to accept hospital treatment; otherwise see paragraph 20 of the VA Medical Bulletin No. 1.

the Veterans Administration can make reimbursement for their treatment, they are responsible for their own medical care and for indebtedness incurred as a result of such medical care. It is well to remember that under existing laws the simple fact of the veteran having served in the military forces of the United States is not considered sufficient to give him, as a veteran, blanket coverage for all the medical care he will need in the future; and to remember, too, that basically the Veterans Administration offers the veteran two services: (1) hospitalization at government expense in a government hospital for any condition, whether service-connected or not, that may require hospital treatment; (2) out-patient treatment in the home, the office, or a private hospital for service-connected disabilities that are found to have been incurred while the veteran was in military service.

LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served
Medical Convention		
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Fort Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibbard, Richmond	1862	1863
*John Sloan, New Albany	1863	1864
*John Moffett (acting), Rushville	1864	1864
*Samuel M. Linton, Columbus	1864	1865
*Wilson Lockhart (acting), Danville	1865	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert M. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Fort Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselbery, Evansville	1873	----
*Wilson Hobbs, Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.-p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Munford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Fort Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William N. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Fort Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Fort Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
Medical Association		
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Winn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
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*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
E. M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
Alois B. Graham, Indianapolis	1929	1931
Franklin Smith Crockett, Lafayette	1930	1932
Joseph H. Weinstein, Terre Haute	1931	1933
Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund Dougan Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
Edmund M. Van Buskirk, Fort Wayne	1937	1939
Karl R. Ruddel, Indianapolis	1938	1940
Albert M. Mitchell, Terre Haute	1939	1941
M. A. Austin, Anderson	1940	1942
C. H. McCaskey, Indianapolis	1941	1943
J. T. Oliphant, Farmersburg	1942	1944
N. K. Forster, Hammond	1943	1945
J. E. Ferrell, Fortville	1944	1946
F. T. Romberger, Lafayette	1945	1947

*Deceased.

INDIANA STATE BOARD OF HEALTH ORGANIZATION, FUNCTIONS AND SERVICES

I. General information

A. Establishment of the State Board of Health

An Act establishing a State Board of Health, consisting of five members, to supervise the interests of the health and life of the Citizens of the State was enacted by the General Assembly in 1881.

Amendment to this Act was made in 1945 by the 84th Session of the General Assembly creating a nine member board appointed by the Governor, three of whom are physicians, one a sanitary engineer, one a pharmacist, one a dentist, one a veterinarian, one a graduate nurse, and one layman. The Secretary of the Board, who also serves as health commissioner, is appointed by the State Board of Health for a term of four years. (Acts of 1945, Chapter 352, Sec. 1-2-3)

B. Present personnel

The present organization of the State Board of Health is as follows:

State Health Commissioner, L. E. Burney, M.D.

1. Bureau of Local Health Administration —Acting Director, George M. Brother, M.D.
 Public Health Nursing—Director, Miss Ethel R. Jacobs, R.N.
 Hospital and Institutional Services—Director, Martha O'Malley, M.D.
 Branch Offices
 Southeastern Branch Office, Columbus —Director, Dan C. Barrett, M.D.
 Northwestern Branch Office, Valparaiso—Director, Wendell C. Anderson, M.D.
 Southwestern Branch Office, Washington—Director, L. W. Frame, M.D.
 West-Central Branch Office, Terre Haute—Director not yet appointed.
 Northeastern Branch Office, Fort Wayne—Director not yet appointed.

2. Bureau of Sanitary Engineering—Director, Mr. B. A. Poole
 Water Supply
 Sewage Disposal
 Industrial Waste
 Stream Pollution
 General Sanitation
 Housing and Schools

3. Bureau of Health Education, Records and Statistics—Director, Mr. Robert Yoho
 Vital Records—Director, Mr. H. G. Wright
 Public Health Statistics—Director, Mr. Robert Serfling
 Health and Physical Education—Director, Mr. Robert Yoho

4. Bureau of Laboratories—Director, Samuel R. Damon, Ph.D.
 Water
 Serology
 Bacteriology
 Dairy Products
 Food and Drugs

5. Bureau of Preventive Medicine—Director, George M. Brother, M.D.
 Tuberculosis—Acting Director, Merle Bundy, M.D.
 Dental Health—Vacancy.
 Venereal Disease — Director, George Bowman, M.D.
 Industrial Hygiene — Director, Louis Spolyar, M.D.
 Communicable Disease—Director, C. W. Jackson, M.D.
 Maternal and Child Health—Director, Robert E. Jewett, M.D.
 Adult Hygiene and Geriatrics—Director, William F. King, M.D.

C. Ten leading causes of death in Indiana

1. Heart Disease
2. Intracranial lesions
3. Cancer
4. Nephritis
5. Pneumonia and Influenza
6. Accidents, exclusive of motor vehicles
7. Tuberculosis
8. Motor vehicle accidents
9. Premature births
10. Diabetes Mellitus

II. Responsibilities of Physicians

A. Reporting cases of communicable diseases by physicians is required by law.

1. Within 24 hours from the time the case is first seen by the physician the patient's name, age, sex, occupation, and address must be reported to the health officer having jurisdiction over the locality in which the case resides. Reporting shall be by telephone or telegram when practicable, and shall also be made in writing. (Quarantine Law, Acts of 1903, Chapter 83, Section 1; Regulation HCD 3-4; effective December 13, 1945). The following communicable diseases shall be reported in the above manner:

 Anthrax, botulism, brucellosis (undulant fever), chancroid, chickenpox, chol-

era (Asiatic), conjunctivitis (gonorrhea), dengue, diphtheria, dysentery amebic (amebiasis), dysentery bacillary, encephalitis, epidemic diarrhea of the newborn, erysipelas, favus, filariasis, food infections, food poisoning, German measles (rubella), glanders, gonococcus infection, granuloma inguinale, hepatitis (infectious), hookworm disease (ancylostomiasis), impetigo contagiosa, influenza, jaundice infectious (Weil's disease), keratoconjunctivitis, leprosy, lymphogranuloma venereum, malaria, measles, meningitis, meningococcus, mumps, paratyphoid fever, pemphigus neonatorum, pertussis (whooping cough), plague (bubonic), pneumonia, poliomyelitis acute anterior, puerperal infections, psittacosis, rabies human, ratbite fever, relapsing fever, rheumatic fever, ringworm of the scalp, Rocky Mountain spotted fever, scarlet fever, septic sore throat, smallpox, syphilis, tetanus, trachoma, trichinosis, tuberculosis, tularemia, typhoid fever, typhus fever, and yellow fever.

2. Physicians shall report IMMEDIATELY to local health officer by telephone or telegraph (Quarantine Law, Acts of 1903, Chapter 83, Section 1; Regulation HCD 3-4; effective December 13, 1945) the following diseases:

 Asiatic cholera, bubonic plague, leprosy, psittacosis, typhus fever, yellow fever, typhoid fever, smallpox, diphtheria, meningococcic meningitis, poliomyelitis, glanders, anthrax, and botulism.

3. Physicians shall report directly to the State Board of Health on special report cards (Quarantine Law, Acts of 1903, Chapter 83, Section 1; Regulation HCD 3-4; effective December 13, 1945) the following diseases:

 Chancroid, gonococcus infection, syphilis, granuloma inguinale, lymphogranuloma venereum, ophthalmia neonatorum.

4. Every case of tuberculosis shall be reported within 24 hours of discovery to the health officer having jurisdiction over the locality in which the case resides. (Acts of 1945, Chapter 193, Section 1; Regulation HT 5; effective October 11, 1945.)

B. Prenatal Law (Serological blood tests for syphilis of pregnant women) Acts of 1939, Chapter 12, Section 1.

 Every physician attending pregnant women in the State of Indiana shall take or cause to be taken a sample of blood of such women at the time of diagnosis, and submit such sample to an approved laboratory for a standard serological test for syphilis.

C. Premarital Law (Seriological blood tests for syphilis before marriage) Acts of 1939, Chapter 100, Section 3.

 Application for a marriage license shall be accepted by the clerk of the circuit court only when accompanied by a statement signed by a duly licensed physician stating that both persons have had a blood test for syphilis and that neither one has the disease in an infectious stage.

D. Reporting Births—Acts of 1945, Chapter 154, Section 6-7

1. Within five days after delivery a certificate of every birth shall be filed with the local health officer of the district in which the birth occurred, by the physician, midwife, or other legally authorized person in attendance at the birth; or if not so attended, by one of the parents.

2. Stillbirths—A stillborn child of twenty weeks or more of utero-gestation shall be reported as "Stillbirth" on the special blue form of certificate which explains itself. This form serves both as a birth and death record. The stillbirth certificate shall be filed with the health officer having jurisdiction over the area where the stillbirth occurred.

E. Certificate of Deaths—Acts of 1945, Chapter 154, Section 8

 The attending physician shall certify the cause of death on the certificate presented to him by the person in charge of interment.

III. Services available to the physician from the State Board of Health

A. Laboratory Services

 The Bureau of Laboratories is conducted exclusively for benefit of the public's health. Laboratory services which have public health significance are available to physicians without charge. The laboratory **does not interpret** the results of the finding to the physician but reports the results revealed in the given tests. Containers and forms may be obtained from the State Board of Health and local health officers.

1. Bacteriological Laboratory

 Agglutination tests for enteric fevers, undulant fever, tularemia, typhus, Rocky

Mountain spotted fever, and infectious mononucleosis.

Blood, stool, and urine cultures for typhoid.

Blood cultures for brucellosis.

Stool examination for intestinal parasites.

Stool cultures for dysentery.

Blood films for malaria.

Pus smears for gonocci and trichomonas.

Sputum examination for acid fast organisms and fungi.

Sputum cultures and animal inoculations for tuberculosis.

Nose and throat cultures for diphtheria and Vincents infection.

Examination of animal brains for rabies.

2. Serological Laboratory

Blood tests for syphilis (the Mazzini test is run as a screen test, and a Wassermann test is run as a diagnostic test on all specimens showing any degree of reaction with the Mazzini technic).

Spinal fluid tests for syphilis (colloidal gold and Wassermann).

Complement fixation tests for gonorrhea and tuberculosis.

3. Water and Sewage Laboratory

Tests for water. Only official containers as supplied by the State Board of Health will be accepted by the laboratory.

*4. Dairy Products Laboratory

*5. Food and Drug Laboratory

6. Records and Reports

Permanent file records of laboratory results are maintained in the Bureau of Laboratories and are available to physicians for reference.

B. Communicable Diseases and Industrial Diseases Consultant Services

Advisory and consultant services by trained persons are available to the physician upon request for the prevention and amelioration of communicable and industrial diseases.

Industrial laboratory facilities are available for the detection of urinary leads and industrial poisons.

C. Professional films for in-service training

A number of 16 mm. motion picture films, suitable for showing before professional medical groups, are available for loan without charge to medical societies for scientific programs. Included in the library are films on obstetrics, pediatrics, and communicable diseases. Lists of professional and lay health films will be sent on request.

D. Group X-ray screening on a county-wide basis.

The State Board of Health has two 70 mm. X-ray units which are available for county use on request by the local health officer with the written approval of the local medical society. The group X-ray is used as a survey or screening process to facilitate a large coverage of persons. It is not a diagnostic procedure. Equipment, technicians, film, and processing of the film are provided. The responsibility of interpreting the film is a local one.

E. Biologicals, Blood Products and Drugs

Provisions of Chapter 33, Acts of 1939, authorize the State Board of Health to purchase, distribute and make available free to persons too poor to pay for it themselves anti-pneumococcic serum, and immunizing agents.

Anti-pneumococcic serum is available to all physicians on request directly from the State Board of Health. All other immunization materials are dispensed free on request to local health officers for immunization of indigent persons.

Surplus Army-Navy blood products are available to all hospitals and physicians without charge on request to the State Board of Health. Adequate supplies of normal human dried blood plasma and immune serum globulin for measles prophylaxis are available at the present time. The only provision made with the distribution is that no charge be made for the blood products. The hospitals and physicians may, of course, charge for services rendered in connection with the administration of these products.

Drugs for the treatment of indigent venereal disease patients are also available to physicians by requisition through local health officers on prescribed forms.

IV. Branch offices of the State Board of Health

Decentralization of the activities of the State Board of Health through the establishment of five branch offices has been completed recently to facilitate the availability of services. At the present time almost all the services formerly available from the central office in Indianapolis are now obtainable from the branch offices.

Requests should be made through the branch office serving the area in which the physician practices.

* It is the policy of the State Board of Health to examine in its laboratories only those samples submitted by an official public health agency (county personnel, health departments, or branch offices of the State Board of Health).

DISEASES WHICH MUST BE REPORTED TO HEALTH OFFICER

THE following diseases should be reported to the local Health Officer. Those in italics must be reported immediately by the health officer to the State Health Department and those capitalized should be reported directly there by the physician.

Anthrax
Botulism
Brucellosis (Undulant Fever)
CHANCROID
Chickenpox
CHOLERA (Asiatic)
CONJUNCTIVITIS (Gonorrheal)
Dengue
Diphtheria
Dysentery (Amebic)
Dysentery (Bacillary)
Encephalitis
Epidemic Diarrhea of Newborn
Erysipelas
Favus
Filariasis
Food Infections
Food Poisoning
German Measles (Rubella)
Glanders
GONOCOCCUS INFECTIONS
GRANULOMA INGUINALE
Hepatitis, Infectious
Hookworm Disease
Impetigo Contagiosa
Influenza
Jaundice, Infectious (Weil's)
Keratoconjunctivitis
Leprosy
LYMPHOGRANULOMA INGUINALE
Malaria
Measles
Meningitis, Meningococcus
Mumps
Paratyphoid Fever
Pemphigus neonatorum
Pertussis (Whooping Cough)
Plague (Bubonic)
Pneumonia
Poliomyelitis
Puerperal Infections
Psittacosis
Rabies, Human
Ratbite Fever
Relapsing Fever
Rheumatic Fever
Ringworm of the Scalp
Rocky Mountain Spotted Fever
Scarlet Fever
Septic Sore Throat
Smallpox
SYPHILIS
Tetanus
Trachoma
Trichinosis
Tuberculosis
Tularemia
Typhoid Fever
Typhus Fever
Yellow Fever

LAWS AND RULES

"It shall be the duty of every physician to report to the local health officer, within whose jurisdiction the patient is, the full name, age, sex, occupation and address of every person apparently affected with a communicable disease within twenty-four hours."

"The head of a private household, the head of an institution, school, hotel, boarding house, camp or vessel or any public health nurse or any other person having actual knowledge of an individual infected with a communicable disease, shall report to the local health officer cases, or suspected cases, occurring within his sphere of authority."

"It shall be the duty of the attending physician immediately upon discovering a case of communicable disease to cause the patient to be isolated, pending official action by the health officer. Such physician shall also advise other members of the household regarding precautions to be taken to prevent further spread of the disease and shall inform them as to appropriate specific preventive measures. He shall in addition furnish the patient's attendant with such detailed instructions regarding the disinfection and the disposal of infective secretions and excretions in an effective manner."

* * *

Patients with chickenpox, German measles, whooping cough and mumps will be excluded from school. Contacts need not be excluded. Immune contacts to measles need not be excluded. Contacts with diphtheria, scarlet fever, meningitis, poliomyelitis and smallpox will be excluded from school within the incubation period or until shown not to carry the disease. Exclusion for chickenpox is one week or until crusts disappear, for mumps until signs of the disease disappear, for pertussis three weeks, for German measles one week, for diphtheria ten days or after two negative nose and throat cultures, for measles five days after the rash disappears and all abnormal secretions from the mucous membranes have ceased, for meningococcus meningitis three weeks, for poliomyelitis fourteen days, for smallpox until all lesions are healed. The exclusion for contacts, not any longer exposed to the disease, is the longest usual incubation period or until negative cultures are obtained in those diseases in which this is practicable.

Premises will be placarded for diphtheria for not less than ten days, for measles for not less than five days after the appearance of the rash, for pertussis for twenty-one days, for meningitis for two weeks, for poliomyelitis for two weeks, for smallpox until all lesions are gone, for scarlet fever for from fourteen to twenty-eight days as determined by the health officer with the attending physician. Children with streptococcic sore throat will be excluded from school for two weeks.

These rules comply with the laws and regulations of the state.

Human immune globulin is available here through the State Board of Health as a temporary immunizer and measles modifier.

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AMERICAN MEDICAL ASSOCIATION

535 N. Dearborn Street

Chicago 10, Illinois

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APPROVED HOSPITALS AND SANITARIUMS IN INDIANA

City	Type	Beds
Anderson		
Hoppes Lying-in Hospital	Mat	12
St. John's Hickey Memorial Hospital	Gen.	20
Angola		
Cameron Hospitals	Gen.	20
Argos		
Kelly Hospital	Gen.	10
Auburn		
Dr. Bonnell M. Souder Hospital	Gen.	30
Batesville		
Margaret Mary Hospital	Gen.	75
Bedford		
Dunn Memorial Hospital	Gen.	60
Beech Grove		
St. Francis Hospital	Gen.	150
Bloomington		
Clinic Hospital	Gen.	40
Bluffton		
Clinic Hospital	Gen.	43
Wells County Hospital	Gen.	25
Clinton		
Vermillion County Hospital	Gen.	50
Columbus		
Bartholomew	Gen.	75
Connersville		
Fayette Memorial Hospital	Gen.	44
Crawfordsville		
Culver Hospital	Gen.	85
Crown Point		
James O. Parramore Hospital	T.B.	284
Decatur		
Adams County Memorial Hospital	Gen.	47
Dyer		
Mount Mercy Sanitarium	N.&M.	75
East Chicago		
St. Catherine's Hospital	Gen.	264
Elkhart		
Elkhart General Hospital	Gen.	75
Elwood		
Mercy Hospital	Gen.	45
Evansville		
Boehne Tuberculosis Hospital	T.B.	130
Clearview	N.&.M.	30
Evansville State Hospital	Ment.	1,200
Protestant Deaconess Hospital	Gen.	225
St. Mary's Hospital	Gen.	169
U. S. Marine Hospital	Gen.	95
Welborn Memorial Baptist Hospital	Gen.	100
Fort Wayne		
Irene Byron Sanatorium	T.B.	254
Lutheran Hospital	Gen.	187
Methodist Hospital	Gen.	100
St. Joseph Hospital	Gen.	290
Frankfort		
Clinton County Hospital	Gen.	40
Garrett		
Sacred Heart Hospital	Gen.	42
Gary		
Methodist Hospital	Gen.	206
Patients' Hospital	Gen.	40
St. John Hospital	Gen.	25
St. Mary's Mercy Hospital	Gen.	220
Greencastle		
Putnam County Hospital	Gen.	45
Greensburg		
Decatur County Memorial Hospital	Gen.	40
Hammond		
Mount Mercy Sanitarium	N.&M.	35
St. Margaret Hospital	Gen.	236
Hartford City		
Blackford County Hospital	Gen.	22
Huntingburg		
Stork Hospital	Gen.	12
Huntington		
Huntington County Hospital	Gen.	46
Indianapolis		
Central State Hospital	Ment.	2,292
Emhardt Memorial Hospital	Gen.	36
Flower Mission Memorial Hospital (Unit of Indpls. City Hosp.)		
Indianapolis City Hospital	Gen.	700
Indiana University Medical Center	Gen.	584
James Whitcomb Riley Hospital for Children (Unit of I. U. Medical Center)		
Kiwanis Home (Unit of I. U. Medical Center)		
Methodist Hospital	Gen.	606
"Norways" Sterne Memorial Hospital	N.&M.	32
Public Health Center	Gen.	147
Robert W. Long Hospital (Unit of I. U. Medical Center)		
Rotary Convalescent Home (Unit of I. U. Medical Center)		
St. Vincent's Hospital	Gen.	322
Sunnyside Sanatorium	T.B.	248
Veterans' Administration Center	Gen.	345
William H. Coleman Hospital for Women (Unit of I. U. Medical Center)		
Jeffersonville		
Clark County Memorial Hospital	Gen.	85
Kendallville		
McCray Memorial Hospital	Gen.	32
Kokomo		
St. Joseph Memorial Hospital	Gen.	81
Lafayette		
Lafayette Home Hospital	Gen.	145
St. Elizabeth Hospital	Gen.	285
William Ross Sanatorium	T.B.	27

City	Type	Beds
LaPorte		
Fairview Hospital	Gen.	72
Holy Family Hospital	Gen.	111
Lebanon		
Witham Memorial Hospital	Gen.	70
Linton		
Freeman Greene County Hospital	Gen.	30
Logansport		
Cass County Hospital	Gen.	70
Logansport State Hospital	Ment.	2,395
St. Joseph Hospital	Gen.	60
Madison		
Kings Daughters Hospital	Gen.	50
Marion		
Marion General Hospital	Gen.	80
Veterans' Administration Hospital (See Veterans' Administration Hospital, Ind.)		
Martinsville		
Morgan County Memorial Hospital	Gen.	30
Michigan City		
Clinic Hospital	Gen.	50
Indiana Hospital for Insane Criminals	Ment.	342
Indiana State Prison Hospital	Inst.	180
St. Anthony's Hospital	Gen.	100
Warren Hospital	Gen.	22
Mishawaka		
St. Joseph Hospital	Gen.	100
Mooresville		
Comer's Sanitarium	Proct.	15
Muncie		
Ball Memorial Hospital	Gen.	217
New Albany		
St. Edward Hospital	Gen.	114
"Silvercrest" Southern Indiana Tuberculosis Hospital	T.B.	152
New Castle		
Clinic Hospital	Gen.	19
Henry County Hospital	Gen.	82
North Madison		
Madison State Hospital	Ment.	1,580
Peru		
Dukes-Miami County Memorial Hospital	Gen.	60
Wabash Railroad Employees Hospital	Indus.	50
Plymouth		
Parkview Hospital	Gen.	33
Portland		
Jay County Hospital	Gen.	53
Princeton		
Gibson General Hospital	Gen.	41
Rensselaer		
Jasper County Hospital	Gen.	42
Richmond		
Reid Memorial Hospital	Gen.	130
Richmond State Hospital	Ment.	1,732
Smith-Esteb Memorial Hospital	T.B.	50
Rockville		
Indiana State Sanatorium	T.B.	250
Rome City		
Kneipp Springs Sanatorium	Gen.	150
Rushville		
Rushville City Hospital	Gen.	12
Seymour		
Schneck Memorial Hospital	Gen.	62
Shelbyville		
W. S. Major Hospital	Gen.	48
South Bend		
Healthwin Hospital	T.B.	185
Memorial Hospital	Gen.	230
St. Joseph's Hospital	Gen.	181
Sullivan		
Mary Sherman Memorial Hospital	Gen.	50
Tell City		
Parkview Hospital	Gen.	12
Terre Haute		
Hoover's Sanatorium	Gen.	14
St. Anthony's Hospital	Gen.	176
Union Hospital	Gen.	189
U. S. Penitentiary Hospital	Inst.	100
Union City		
Union City Hospital	Gen.	12
Valparaiso		
Porter Memorial Hospital	Gen.	57
Veterans' Administration Hospital	Ment.	2,093
Vincennes		
Good Samaritan Hospital	Gen.	109
Hillcrest Tuberculosis Hospital	T.B.	65
Wabash		
Wabash County Hospital	Gen.	45
Warsaw		
McDonald Hospital	Gen.	38
Murphy Medical Center	Gen.	25
Washington		
Daviess County Hospital	Gen.	93
Williamsport		
Community Hospital	Gen.	20
Winchester		
Randolph County Hospital	Gen.	37
Wolflake		
Luckey Hospital	Gen.	20

RELATED INSTITUTIONS

Anderson		
Citizens Nursing Center	Gen.	13
Ella B. Kehrer Hospital	T.B.	45
Butlerville		
Muscatatuck State School	MeDe.	1,320
Fort Wayne		
Fort Wayne State School	MeDe.	1,912
Grace Convalescent Hospital	Conv.	33
Medical Center Hospital	Gen.	25
Greencastle		
Indiana State Farm Hospital	Inst.	31

City	Type	Beds
Greensburg		
Odd Fellows Home Hospital	Inst.	47
Hammond		
Kuhn Clinic Hospital	ENT.	15
Indianapolis		
Suemma Coleman Home	Mat.	20
Lafayette		
Indiana State Soldiers' Home Hospital	Inst.	112
Lagrange		
Lagrange County Hospital	Gen.	14
Martinsville		
Home Lawn Mineral Springs	Conv.	162
Martinsville Sanitarium	Conv.	120
New Castle		
Indiana Village for Epileptics	Epil.	1,035
Pendleton		
Indiana State Reformatory Hospital	Inst.	86
Plainfield		
Indiana Boys' School Hospital	Inst.	27
Wilkinson		
Dr. Charles Titus Hospital	ENT.	7

Institutions Operated by the State of Indiana

State Prison, Michigan City—Ralph Howard, warden.

Indiana Reformatory, Pendleton—Russell D. Moore, superintendent.

State Farm, Greencastle—Albert E. Virgil, superintendent.

Woman's Prison, Indianapolis—Mrs. Ethel Krueger, superintendent.

Boys' School, Plainfield—Albert H. Jessup, superintendent.

Girls' School, Indianapolis—Mrs. Adeline C. Lehman, superintendent.

Central State Hospital, Indianapolis—Max A. Bahr, M.D., superintendent.

Evansville State Hospital, Evansville—John H. Hare, M.D., superintendent.

Madison State Hospital, Madison—George W. Boner, M.D., superintendent.

Logansport State Hospital, Logansport—C. C. Chapin, M.D., superintendent.

Richmond State Hospital, Richmond—O. R. Lynch, M.D., superintendent.

Fort Wayne State School, Fort Wayne—Luther T. Hurley, superintendent.

Southern Indiana Tuberculosis Hospital, New Albany—John V. Pace, M.D., superintendent.

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Indiana Village for Epileptics, New Castle—W. C. Van Nuys, M.D., superintendent.

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PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

CHAPTER I

In General.

Section 1. The Physician's Responsibility.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

Sec. 2. Groups and Clinics.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

The Duties of Physicians to Their Patients.

Section 1. Patience, Delicacy and Secrecy.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would

desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

Sec. 2. Prognosis.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

Sec. 3. Patients Must Not Be Neglected.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

The Duties of Physicians to Each Other and to the Profession at Large.

ARTICLE I.—Duties to the Profession.

Section 1. Uphold Honor of Profession.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

Sec. 2. Medical Societies.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

Sec. 3. Deportment.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty without anxiety: pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

Sec. 4. Advertising.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

Sec. 5. Patents and Perquisites.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

Sec. 6. Medical Laws—Secret Remedies.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

Sec. 7. Safeguarding the Profession.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—Professional Services of Physicians to Each Other.

Section 1. Physicians Dependant on Each Other.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

Sec. 2. Compensation for Expenses.—When a physician from a distance is called on to advise another physician or one of his family dependants, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

Sec. 3. One Physician to Take Charge.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physi-

cian from among his neighboring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III.—Duties of Physician in Consultations.

Section 1. Consultations Should Be Encouraged.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

Sec. 2. Consultation for Patient's Benefit.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

Sec. 3. Punctuality.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

Sec. 4. Patient Referred to Specialist.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

Sec. 5. Discussions in Consultation.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

Sec. 6. Attending Physician Responsible.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

Sec. 7. Conflict of Opinion.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

Sec. 8. Consultant and Attendant.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—Duties of Physicians in Cases of Interference.

Section 1. Misunderstandings to Be Avoided.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

Sec. 2. Social Calls on Patient of Another Physician.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

Sec. 3. Services to Patient of Another Physician.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

Sec. 4. Criticism to Be Avoided.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

Sec. 5. Emergency Cases.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

Sec. 6. When Several Physicians are Summoned.—

When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

Sec. 7. A Colleague's Patient.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

Sec. 8. Relinquishing Patient to Regular Attendant.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

Sec. 9. Substituting in Obstetric Work.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—Differences Between Physicians.

Section 1. Arbitration.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—Compensation.

Section 1. Limits of Gratuitous Service.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

Sec. 2. Conditions of Medical Practice.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

Sec. 3. Contract Practice.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principles or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice **per se** is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not **per se** cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

Sec. 4. Commissions.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

Sec. 5. Direct Profit to Lay Groups.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

The Duties of the Profession to the Public.

Section 1. Physicians as Citizens.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

Sec. 2. Public Health.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk of his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

Sec. 3. Public Warned.—Physicians should warn the public against the devices practiced and the false pretensions made by charlatans which may cause injury to health and loss of life.

Sec. 4. Pharmacists.—By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

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CONSTITUTION AND BY-LAWS OF THE INDIANA STATE MEDICAL ASSOCIATION

ARTICLE I—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state medicine, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV—COMPOSITION OF THE ASSOCIATION

Section 1—This Association shall consist of Members, Delegates, Guests, and Associate and Honorary Members.

Sec. 2—*Members*—The members of this Association shall be the members of the component county medical societies. Membership in a county medical society on a basis not including membership in the Indiana State Medical Association is not recognized.

Sec. 3—*Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4—*Associate Members*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 5—*Honorary Members*—Honorary members shall consist of representative teachers and students of science allied to medicine and of physicians and surgeons of distinction not members of the Indiana State Medical Association, who may by vote of the House of Delegates be elected to honorary membership; and any physician of the State of Indiana who has attained the age of seventy-five years and has held membership in the Indiana State Medical Association for twenty years or more may be elected to honorary membership by vote of the House of Delegates, provided his name be proposed for such honorary membership by the county medical society of which such physician is a member.

Sec. 6—*Guests*—Any distinguished physician not a resident of this state who is a member of his own State Association may become a guest during any Annual Session on invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that session.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; (3) the ex-Presidents of the Indiana State Medical Association; and (4) *ex officio* the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President shall cast the deciding vote.

ARTICLE VI—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, Executive Secretary, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Five Councilors shall constitute a quorum.

ARTICLE VII—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII—SESSIONS AND MEETINGS

Section 1—The Association shall hold an Annual Session during which there shall be held daily general meetings and such section meetings as may be provided for, all of which shall be open to all registered members and guests.

Sec. 2—The time and place for holding each Annual Session shall be fixed by the House of Delegates at the preceding Annual Session.

Sec. 3—Special sessions of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX—OFFICERS

Section 1—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed.

Sec. 3—The officers of this Association shall be elected by the House of Delegates on the morning of the last day of the Annual Session, and no person shall be elected to any such office who is not in attendance on that Annual Session and who has not been a member of the Association for the preceding two years.

Sec. 4—The Councilors shall be elected by the respective district societies, providing that if any district shall exist without a society, or if the district society fails to meet and elect its Councilor and notify the House of Delegates before or at the time of the Annual Session, the Councilor for such a district shall be elected by the House of Delegates. Provided further, That if a Councilor district society fails to meet and elect its Councilor, the Councilor for that district shall be elected by the House of Delegates.

ARTICLE X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI—FUNDS AND EXPENSES

Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds also may be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publication, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII—REFERENDUM

Section 1—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it

shall have been published twice during the year in THE JOURNAL of this Association.

BY-LAWS

CHAPTER I—MEMBERSHIP

Section 1—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association.

Sec. 2—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 3—Each member in attendance at the Annual Session shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that session. No member shall take part in any of the proceedings of an Annual Session until he has complied with the provisions of this section.

CHAPTER II—GENERAL MEETINGS

Section 1—All registered members may attend and participate in the proceedings and discussions of the General Meetings and the meetings of the sections. The General Meetings shall be presided over by the President or by the President-elect, and before them shall be delivered the address of the President and the orations, unless the Committee on Scientific Work, with the sanction and approval of the officers, shall arrange otherwise.

Sec. 2—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3—No address or paper before the Association, except those of the President and orators, shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes nor more than once on any subject, except by unanimous consent, except the first discussant, who shall be allowed ten minutes.

Sec. 4—All papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each paper shall be deposited with the Executive Secretary when read.

Sec. 5—The Indiana State Medical Association shall appropriate from its funds the sum of Five Hundred Dollars ($500) annually for the entertainment of its members and guests, this money to be expended at the direction of the President, Executive Secretary, and Treasurer of the State Association, and the Chairman of the Entertainment Committee, who is appointed annually by the President of the Association. All money in excess of that expended for actual expenses incurred at that session is to revert each year to the treasury of the State Association.

CHAPTER III—SECTIONS

Section 1—During the Annual Session the Association may meet in the following sections:

a. Surgical.

b. Medical.

c. Eye, Ear, Nose, and Throat.

d. Anesthesia.

e. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3—The election of officers of the sections shall be the first order of business of the last meeting of the sections during the Annual Session.

Sec. 4—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV—HOUSE OF DELEGATES

Section 1—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Session. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the morning of the last day of the Annual Session for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate to be selected by the physicians residing in such county. The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before June first prior to the Annual Session at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the President and Secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Session. If any component county medical society is without representation at the end of the roll call, then the members registered in attendance from that county may select from their number a delegate to serve until the regular delegate or alternate appears, and any delegate so named must receive a vote of affirmation from the House of Delegates before he can be seated.

Sec. 3—Twenty delegates shall constitute a quorum.

Sec. 4.—It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Sec. 5—It shall divide the state into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

Sec. 6—It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such comittees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

Sec. 7—It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 8—Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 9—At the first meeting the President shall appoint from among the members of the House of Delegates, Reference Committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

CHAPTER V—ELECTION OF OFFICERS

Section 1—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the Annual Session.

Sec. 2—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4—The term of office, unless otherwise specified, shall be for the fiscal year following the date of election.

CHAPTER VI—DUTIES OF OFFICERS

Section 1—The President shall preside at all General Meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Scientific or Program Committee, and perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties. In the event of the President's death, resignation or removal, the President-elect shall succeed him in office.

Sec. 3—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall demand and receive all funds due the Association, except accounts due THE JOURNAL in the conduct of its business, together with bequests and donations. He shall pay money out of the treasury only on a written order by the President, countersigned by the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to such examination as the House of Delegates may order.

Sec. 4—The Executive Secretary shall attend the General Meetings of the Association, and the meetings of the House of Delegates and the Council, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of all committees of the Association, assist them in the performance of their duties and keep a record of their proceedings. He shall, under instructions from the Bureau or Committee on Publicity, issue and send to lay publications such educational articles as may be prepared and authorized for general publication, and secure and assign medical speakers to address (on invitation) lay organizations on subjects pertaining to individual or community health. He also shall, whenever requested, assist any of the component societies of the Association in securing speakers or otherwise preparing a program for special meetings; he shall at all times hold himself in readiness to advise and aid, so far as practicable, any and all officers or committees of the Association in the performance of their duties or to carry out any of the purposes or policies of the Association. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall be bonded at the expense of the Association in such an amount as shall be required by the Council. He shall provide for the registration of the members and delegates at the Annual Session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and, on request, shall transmit a copy of this list to the American Medical Association. He shall report promptly memberships and proceedings or reports of the House of Delegates, the Council, or any committees of the Association to the Editor of THE JOURNAL for publication. He shall aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council, and shall make an annual report to the House of Delegates. He shall supply each component society with the necessary blanks for making their annual reports; shall keep an account with the component societies, charging against each society its assessments, collect the same, and at once turn it over to the Treasurer. Acting with the Committee on Scientific Work and the Editor of THE JOURNAL, he shall prepare and issue

all programs. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expense of attending the Annual Session.

CHAPTER VII—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April and July of each year. 2. On the day preceding the first day for the scientific meetings of the Annual Session of the Association. 3. On the last day of the Annual Session of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman; and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. Five Councilors shall constitute a quorum for the transaction of business.

Sec. 2—Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Session, and the report should be approved by the House of Delegates, with such recommendations as seem indicated. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Sec. 3—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Session a stepping stone to future ones of higher interest.

Sec. 4—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Session and be published in the number of THE JOURNAL which immediately precedes the Annual Session.

Sec. 11—In the interim between the sessions of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12—The Council shall employ an Executive Secretary, who need not be a physician nor a member of the Association.

Sec. 13—The Council shall elect two members of the Association, who, with the President, the President-elect, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

CHAPTER VIII—STANDING COMMITTEES

Section 1—The standing committees shall be as follows:

The Executive Committee.
A Committee on Arrangements.
A Committee on Scientific Work.
A Committee on Public Policy and Legislation.
A Committee on Publicity.
A Committee on Industrial and Civic Relationship.
A Committee on Medical Education and Hospitals.
A Committee on Budget.
A Committee on Public Relations.

Such committees, except the Executive Committee, which is elected by the Council, and the Committee on Budget, the membership of which is hereinafter provided for, shall be appointed by the President of the Association, and the President and Executive Secretary of the Association shall be *ex officio* mem-

bers of all standing committees. The President also may appoint such other committees as may be necessary. No member of the Indiana State Medical Association shall serve as a member of two major committees in any one year.

Sec. 2—*The Executive Committee*, consisting of five members as heretofore provided for, shall meet regularly once a month with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Constitution. It shall represent the Council during intervals between meetings of that body and shall report its doings to the Council.

Sec. 3—*The Committee on Arrangements*, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and commercial exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all commercial exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4—*The Committee on Scientific Work* shall consist of three members, one to serve one year, one to serve two years, and one to serve three years, thereafter one to be appointed each year for a period of three years; the senior member to be Chairman.

The President, the officers of the sections, and the Executive Secretary are to be *ex officio* members.

Liaison shall be maintained between the Committee on Scientific Work and the scientific exhibitors. Thirty days previous to each Annual Session it shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented. Such program and all announcements concerning the Annual Session shall be published in the number of THE JOURNAL of the Association that is issued just prior to the Annual Session.

Sec. 5—*The Committee on Public Policy and Legislation* shall consist of three members and the President and Executive Secretary of the Association. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine and the economic welfare of the medical profession. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and to protect the medical profession, and shall strive to organize professional influence so as to promote the general good of the community in local, state and national affairs and elections.

Sec. 6—*The Committee on Publicity* shall consist of five members, two of which shall be the President and the Executive Secretary of the Association. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, or for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 7—*The Committee on Industrial and Civic Relationship* shall consist of three members appointed by the President, each to serve for three years, one member to be appointed each year. The duties of the committee shall be: To study, gather facts and become intimately acquainted with all and every movement wherever and by whomsoever agitated, proposed, enacted or attempted to be enacted, that has as its secret or avowed object the providing of social, commercial or industrial medical insurance for the public, civic or commercial employers, or for the providing of medical or surgical care to a group or groups of individuals, singly or collectively, or which in any manner affects the economic and financial status of the members of this Association either individually or collectively; to represent this Association in efforts to secure greater cooperation and a mutual understanding between medical men and employers of labor or their insurance carriers concerning the rendering of professional services in industrial cases and the amount and character of compensation therefor; to devise and advise, whenever necessary, intelligent action on the part of this Association upon these questions; and to report annually, and in writing, its findings, recommendations and information to the House of Delegates. Should occasion arise in the interval between the stated meetings of the House of Delegates when prompt action becomes imperative, the committee is to present its findings to the Chairman of the Council and President, who are to proceed in such emergencies as empowered by this Constitution and By-Laws.

Sec. 8—*The Committee on Medical Education and Hospitals* shall consist of three members appointed by the President, each to serve for three years, one member to be appointed each year. The duties of this committee shall be to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 9—*The Committee on Budget* shall consist of the officers, the retiring President and the chairman of the Council. The duty of this committee shall be to prepare a budget for the ensuing year, and all expenditures of the Association, except those otherwise provided for by the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses, which request may be granted by two-thirds vote of the Budget Committee.

Sec. 10—*The Committee on Public Relations* shall have as its duty to act as liaison between the Indiana State Medical Association, the Indiana University School of Medicine, the Indiana State Board of Health, and the public; to hear and investigate complaints, to gather facts, and so far as it may be in their province, to correct existing faults and incorrect information; to further cooperation; and to obtain proper and legitimate publicity through the Publicity Committee of all matters of public interest concerning the above.

CHAPTER IX—REFERENCE COMMITTEES

Section 1—Immediately after the organization of the House of Delegates at each Annual Session, the President shall appoint from the members of the House, reference committees to serve during the session at which they are appointed. Selection of these reference committees shall be made by the President and his advisors at a time sufficiently in advance of the Annual Session, so that the roster of the committees may be published in THE JOURNAL and/or Hand Book prior to said Annual Session. Such publication shall constitute notification of appointment of the various delegates to their respective committees. Absenteeism shall be reported immediately to the President, who then will substitute from among those present. Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work. The members of the Committee on Scientific Work shall be members *ex officio* of this committee.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals. The members of the standing committee on Medical Education and Hospitals shall be *ex officio* members of this committee.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the state, or to the President of the United States. The members of the standing committee on Public Policy and Legislation shall be *ex officio* members of this committee.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity. The members of the standing committee on Publicity shall be *ex officio* members of this committee.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

CHAPTER X—COUNTY SOCIETIES

Section 1—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of the said component society to conduct itself in harmony with the letter and/or spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

Sec. 2—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and/or spirit of this Constitution and By-Laws.

Sec. 3—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7—When a member in good standing in a component society moves to another county in this state, his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10—At the annual business meeting for election of other officers, in advance of the Annual

Session of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before June first.

Sec. 11—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Sec. 12—The fiscal year of the Association shall be from January 1, to December 31, and all assessments shall be for the fiscal year and *payable in advance.* The secretary of each component society shall forward the assessment for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the assessment for such new members. The assessment shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the assessment to the close of the fiscal year only.

Sec. 13—Any county society which fails to pay its assessment or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues or assessments to the Association.

Sec. 15—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER XI—MISCELLANEOUS

Section 1—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XII—MEDICAL DEFENSE

Section 1—Seventy-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2—The administration of medical defense of this Association shall be entrusted to the Executive Committee, which shall constitute the Committee on Defense of the Association.

Sec. 3—This committee shall have full authority governing all matters pertaining to the Medical Defense features of this Association; with power to employ counsel, summon and employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4—The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President and the Chairman of the Council.

Sec. 5—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published. The financial report of the committee shall be submitted to and approved by the Council.

Sec. 6—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7—The Association shall not undertake the defense of a member in a suit that may be brought to secure indemnity for services rendered prior to January 1, 1912, nor in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. (Dues are payable on January 1, and become delinquent on February 1 of each year.) The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8—A member desiring to avail himself of the services of the Committee on Medical Defense in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the

data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Committee on Medical Defense of this Association.

Sec. 10—Accompanying such report from the county society, if favoring medical defense by the Association, there also must be furnished the written authority of the defendant granting to the Medical Defense Committee of this Association full power to act in his behalf, and an agreement that his case shall not be compromised or settled without the consent of a majority of the Committee on Medical Defense.

Sec. 11—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Committee on Medical Defense of this Association, whose decision shall be final.

Sec. 12—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 13—Each member of the Committee on Medical Defense of this Association shall be entitled to an honorarium of $10 per diem for services actually rendered while at home, and $30 per diem with traveling expenses, if required to go out of town in the investigation of any case or in attendance at court, and these same fees shall be allowed to expert witnesses under similar circumstances.

Sec. 14—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 15—The Committee on Medical Defense shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 16—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XIII—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XIV—AMENDMENTS

Section 1—These By-Laws may be amended at any Annual Session by a majority vote of all the delegates present at that session, after the amendment has lain on the table for one day.

Sec. 2—Upon the adoption of this Constitution and By-Laws, all previous Constitutions and By-Laws are hereby repealed.

HOOSIERS INVITED TO RURAL HEALTH CONFERENCE

The second annual National Conference on Rural Health, sponsored by the Committee on Rural Medical Service of the American Medical Association, will be held in the Palmer House in Chicago, Friday and Saturday, February 7 and 8, 1947. Dr. F. S. Crockett of Lafayette, who is chairman of the committee, will preside.

All members of the Indiana State Medical Association are invited to the meeting. Among prominent persons on the program February 7 are Albert S. Goss, of Washington, D. C., master, the National Grange; Dr. Fred A. Humphrey, Fort Collins, Colo., chairman of the Colorado State Medical Society's Committee on Rural Medical Service; H. E. Slusher, Jefferson City, Mo., president of the Missouri Farm Bureau Federation; Mrs. Roy C. Weagly of Hagerstown, Md., president of the Associated Women of the American Farm Bureau Federation; Dr. Robin C. Buerki of Philadelphia, dean of the Graduate School of Medicine, University of Pennsylvania; Dr. James R. McVay of Kansas City, vice-chairman of the A.M.A. Council on Medical Service, and many others.

At a luncheon February 8, which concludes the conference, speakers will be Hon. J. Melville Broughton of Raleigh, N. C., former Governor of North Carolina; Dr. Harrison Shoulders of Nashville, Tenn., president of the American Medical Association, and Dr. Olin West, also of Nashville, Tenn., president-elect of A.M.A.

On Sunday, February 9, the National Conference on Medical Service will meet morning and afternoon in the Palmer House. Dr. Cleon A. Nafe of Indianapolis is the president of this organization. Hoosier physicians are invited to attend this program.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

1947

COMES again the New Year, with all the hopes that a new year brings; a time when we well may take a little personal inventory, to see just what we have done in the past and what we hope to accomplish in the next year. As usual, it is the time for new resolutions, many of which will be observed, many probably forgotten in the rush of other matters.

We have wished that 1946 might herald the coming of a lasting peace, but the United Nations Council is not ready to announce final plans for such a much-desired state of affairs. However, we still may fervently hope that 1947 is the beginning of a new era, a time for a better understanding between nations, and a time when the "brotherhood of man" will no longer be an Utopian dream.

THE JOURNAL wishes all of our members and readers a real, old-time Happy New Year, the best year of their lives.

THE YEAR BOOK

Herewith we present our members the most comprehensive number ever to be sent to you by THE JOURNAL, The 1947 Year Book. And it is just that, a number to be kept right on your desk, for ready reference. It contains just about all the information one will need during the year, in the matter of medical affairs.

First, and probably most important, is the membership roster, both alphabetically and by counties, with street addresses listed in the major communities.

"What does the medical law say," is a commonly-asked question; here is the answer—the complete medical law of the State of Indiana, including all amendments thereto, since its enaction, in 1927. Then, too, there is a roster of all Board members, together with the Executive Secretary, Miss Ruth Kirk—her address and telephone number.

Then we have an official list of Association officials, members of the Executive Committee,

Council, et cetera. There also is the complete setup of the Indiana State Board of Health, the State Dental Board, the Board of Pharmacy, the Board of Veterinary Surgeons, along with much other material of general interest to our members.

The compilation of this volume has meant a lot of planning, a lot of real work, and we are pleased to present it to you, feeling that it will be a most acceptable number. We would suggest—rather we would urge—that this number be not laid aside after a cursory examination; it contains information that will be of benefit to you throughout the year.

In addition to the various boards and medical laws, there is a vast amount of information of an economic nature. Do you want to get the real "low-down" on tax matters and insurance? Well, here you have the correct answers.

We trust our members will have as much pleasure in the use of this number as the editorial staff has had in its compilation. We feel we have done a big job and that we have done it well.

THE HOSPITAL STAFF

Not long after a hospital had been newly established in a community it was recognized that there should be some sort of staff organization. Years ago these were of the "crude" type, usually meaning that there was elected a staff head and a secretary, with formal meetings few and far between. In fact, most of such meetings were called to meet some emergency that had arisen.

In a short time it became patent that more or less regular meetings were necessary and that a more formal plan of organization should be instituted. Then along came the recommendations of the Hospital Committee of the American Medical Association, later a set of suggestions from the American College of Surgeons. At first, these were in the nature of suggestions and recommendations—later on they became "musts."

In more recent years it has been recognized that even with all these suggestions and orders, much remained to be done, to bring about a higher degree of efficiency in hospital staff affairs, so it was no surprise when several such institutions were told to make drastic changes in their staff organization.

Three or four decades ago staff meetings in the smaller hospitals about the country were drab affairs; no formal program, and practically no discussion of local case records. Most members attended just often enough to meet the attendance requirements, and as for the presentation of a hospital case, there was just nothing of the sort.

Later on there came a practice that has been growing, growing to such an extent that a stop order has been issued by the "powers." We refer to the custom of having out-of-town guest speakers. As a matter of fact, many staff organizations patterned their meetings along the lines used in the local county medical society. In other words, they were definite competitors of the latter group. They had one advantage, in that attendance requirements meant that there always would be an audience for their speakers, but the fact remains that such staff meetings were not at all conducive to a building-up of the local county society.

We recall the first Constitution and By-Laws of our local hospital; it contained about two typewritten pages—a very brief bit of document, but one that covered the situation at that time. Later on we held a secret, mail ballot each year, choosing a staff committee and naming the staff head for the next year, but, try as we might, we were unable to place before the staff meetings any considerable number of case reports and in a short time it was discovered that it was much easier to have a guest speaker.

One cause for the paucity of institutional case reports was the fact that one or two members made a practice of discussing such reports outside the hospital, particularly if the member reporting a case had suggested that he had perhaps been in error in his diagnosis or management of the case. Such situations are of course hard to control, but a control may be had.

As of today, most hospitals want to be "recognized"; they want to be "interne-approved" hospitals, and in order to gain this distinction they must meet certain requirements. The medical staff, as a matter of course, wants this, and it is the staff which can make such recognition possible.

So that, when a very lengthy, *complete* Constitution and By-Laws comes from one of the two "governing" bodies, there remains little else to be done but to adopt such recommendations.

There are certain provisions in this document that appeal to us; for example, there will be a new staff head every year, rather than have the same set of officials for several years. But the thing we like most is that the staff meeting shall be just that—a place to discuss what has been going on in *that* hospital during the past month, a frank and free discussion of actual clinical cases.

For many years we have been interested in the weekly staff meetings at one of our largest clinics, a report of which reaches us rather regularly. To our mind, these weekly meetings are exactly what has made this a great clinic. A long time ago one of its founders remarked to us that the success of their institution was due to the fact that every physician connected therewith knew what was going on in every department; that failures, as well as successes, were frankly discussed.

After all, that is what makes Medicine the greatest of the professions—the profiting from the experience of others.

We confidently look forward to a great improvement in hospital staff affairs during the coming year; no longer will it be an adjunct or competitor with the local county medical society; rather will it be a factor of the greatest importance in the medical life of that community.

ANNUAL MEDICAL REGISTRATION

The House of Delegates of the Indiana State Medical Association has gone on record as favoring an annual registration of all practitioners of the healing arts. For a good many years, when this subject was broached, there was enough opposition to delay action in the matter, but in recent years such opposition has died down, and now most physicians agree that such a measure should be enacted by the legislature.

As a matter of fact, ours is the only licensed profession in Indiana that does not pay an annual registration fee, and through the years we never have been able to determine why this should be. For example, we graduated from the Medical College of Indiana in 1902, were duly registered with the Medical Board, took out our county certificate, that fact also being made a matter of record by the Medical Board. From then on, that Board has had no official information about us. For all they know, officially, we may have moved to another county or to another state; we may have died; we may have been placed under lock and key, some place.

With an annual registration requirement all this will be changed; each year the Board will hear from us and will be able to intelligently answer any question as to our whereabouts.

As a member of the Medical Board for a good many years, serving as Executive Secretary for some time, we had a rather intimate knowledge of the many problems that will be solved through an annual registration. Board members, from the day the Board was created, have been harshly criticized "for not doing things." Our critics were of course unreasonable, they were told that we had no funds for law enforcement and that individual members could not afford the time for the necessary investigations of irregular practice.

We recall an instance in Southern Indiana where a retired blacksmith set himself up as a "cancer doctor." In no time he had a large clientele. We went down to see him, one day, on a salary of six dollars for the trip, plus the actual traveling expenses. He gave us a diagnosis of skin cancer, two bottles of medicine, cost $1.50. (We did not collect the professional fee from the State, hence our net "salary" for the trip was $4.50.)

We filed an affidavit against the chap, made two trips to the county seat for his hearing, and the fellow was fined the limit, $200. We were told that on the following Sunday he had "taken in" more than this amount of money! Subsequent arrests were made in this case, but he continued to carry on. And, notwithstanding the many trips we made to that community, there were several physicians in that county who were morally certain that the Board Secretary was taking graft from this man!

With an annual registration fee it will be possible for the Medical Board to employ a full-time investigator, a man trained in this work. He will be able to obtain the necessary evidence leading to prosecution for law violations, and in many instances for revocations of licensure. Other agencies have undertaken such procedures with a fair degree of success, yet they do not have the official backing that would come to a Board investigation.

We are very much in favor of the enactment of an annual registration law, have been for many years; the fee will be two dollars, which will represent a contribution to a fund for the better enforcement of our present and future medical laws.

STREAM POLLUTION CONTROL

One of our fondest dreams of past years was that Indiana finally might awaken and do something about the pollution of our natural waters; at times we felt that perhaps our dreams might be realized; at other times we were completely discouraged about it.

Not long ago a new Board of Control was named and this group was told to get busy on the assignment; officially, it is known as the State Stream Pollution Control Board, which operates hand-in-hand with our State Board of Health.

Health Commissioner Burney, this last summer, had an extensive survey made of the West Fork of White River, in the Indianapolis area, his sanitary engineers reporting a pollution of enormous proportions. Not only in and about Indianapolis, but in Anderson, Muncie, and other central Indiana cities, was this pollution of such proportions. Industrial plants, canning factories, et cetera, were pouring their untreated sewage and waste products into the river, along with city sewage along its course.

At a recent meeting of the Control Board it was voted to "crack down" on the offenders; therefore a notice was sent to all concerned advising that during 1947 these conditions must be remedied. It is stated that some 600,000 Hoosiers use the water from White river for drinking and domestic purposes, and even though filtration beds are used there comes a time when pollution can be so heavy as to make the waters unpotable.

Not too long ago we had the strawboard menace; we had the canning factory menace—all these in addition to the raw sewage unceremoniously dumped into nearby streams, without let or hindrance. Away back in the days of Dr. John N. Hurty this menace to public health was fully recognized, and that good doctor, that pioneer health officer, started a fight against such practices, meeting with not too much success, except in isolated cases.

But now, the picture appears to be different; the great State of Indiana seems to have made up its mind that stream pollution must be stopped; it seems that we have the proper authority and the efficient machinery to bring this thing about.

Both the Control Board and the Board of Health are backing the movement and we feel confident that in due time much of this unnecessary pollution will be stopped.

We never could understand why a civilized people could sit idly by and see the greatest of our natural resources taken away from us. As we frequently have said, we recall the days when one would find clear water in our creeks and rivers; that is just about a thing of the past—but with the proper remedy, properly applied, we may soon again behold the beauties of Dame Nature as expressed in our streams and lakes.

The medical profession is of course in full accord with the program now being launched and may be counted upon to lend a helping hand on every occasion. More power to the two Boards!

Editorial Notes

While we do not anticipate an avalanche of measures inimical to the better interests of medicine, it is morally certain that there will be some that will call for immediate and intense action. We have a most excellent legislative committee, men who have been in the game for years, and who know their way around, but it is too much to expect this small committee to do the whole job, alone; they need the support of all members, and in particular the county medical society officers. Calls will be sent out for this and that, and if these calls are answered without delay, and the information requested be sent in at once it will help the committee, no end. So when you hear from headquarters, get busy and dig up the information asked for and send it right down to the Hume-Mansur Building, pronto.

The local health-officer problem continues to attract much attention on the part of our members; they are well aware that the present "hit-and-miss" system is not workable and are endeavoring to find the best way out. News reports are to the effect that the Vigo County Medical Society recently voted to urge the consolidation of the city and county health units. It also is reported that in the event this is done the Indiana State Board of Health will contribute a sizeable sum, annually, for the carrying on of such a project. In such cases, where we have separate health officers for city and county units, there is too much duplication of effort, which increases the cost very materially. In Lake County, for example, we have four city health departments, plus one rural health department. This has been found to be very unsatisfactory and it is hoped that something soon may be done to remedy the matter.

Rush County has a new committee, known as the Rush County Health Committee. Several local physicians, together with civic leaders, are heading the new organization. This is but another indication that Indiana folk really are health-minded—they are asking a lot of questions—they are getting the answers, some of which they suggest themselves. Physicians will do well to co-operate with all such movements.

While every day is a busy day in both the headquarters office and in THE JOURNAL office, the month of January brings additional duties to both places, at times the staff being literally swamped with work. This year we have the extra problem of meeting the added work brought about by the meeting of the legislature. Members can help a lot, without undue effort, at that. If every member would pay his annual dues, right now, it would help a lot. When dues come dribbling in, sometimes over a period of six months, it places an additional burden on Miss Reid, as well as on Miss Stanley, of the magazine office. This work could be done in a very few days, if everyone paid their dues, right now. Won't you please help us a bit?

Quite some time ago we recorded the "passing of the Monon," Indiana's only real railroad; that is, it extended over the full length of the state, from New Albany to Hammond. It had fallen into evil ways, its new management seemingly having no regard for the future of this famed bit of track. Trains were annulled, freight service cut down, along with many other "retrenchments," until little of the former prestige remained. Today is a different story—completely new management setup, headed by a man who plans to do things—and is doing them. Come another year and we shall see Hoosier streamliners flitting up and down the state; the famous "Hoosier Diner" will have come back into its own—the days of McDowell, Judge Fields and Kurry will have returned and we shall again have our beloved Monon in full splendor.

It is our most fervent wish that along with many other health matters to receive attention at the hands of the 1947 General Assembly the question of "nursing homes" might be given a strict scrutiny, resulting in a law well fortified, with a lot of teeth in it. Nursing homes are much needed, of course, and some of them are doing a most excellent work, while a few have been disgraces to the name of our great state.

This situation can be and must be cleaned up and we trust our lawmakers will give the matter their most serious consideration and give us a real law for our guidance.

Press reports are to the effect that French Lick Springs Hotel has been sold to an Eastern syndicate. This will bring various reactions to many Hoosier "Old timers," who for several decades have been wont to avail themselves of its many advantages of a place for rest and refreshment. French Lick Springs Hotel was founded by Thomas Taggart, Sr., formerly proprietor of the Grand Hotel, Indianapolis, and later of the Denison Hotel of the same city. It might be remembered that "Billy" Holt was the active manager of both institutions. We are pleased to note that Tom Taggart, Jr., probably will remain as chairman of the Board, and still live "up on the hill," near the hostelry. This distinctly is an Indiana institution, one that will, we hope, carry on for many generations to come. Our 1947 convention will be held at this delightful spot where we hope to become acquainted with the new management.

One of the matters that the "revamped" Congress might well do is an investigation of drug advertising, via the radio. There is no rhyme nor reason in permitting radio "blah-blah" to say things that would not be permitted in a newspaper advertisement, yet that is being done every day, right now. Surgeon General Parran, of the Public Health Service, recently expressed himself on this subject, declaring that such practice must be curbed and the radio broadcasters be required to conform to the same rules as apply to newspaper advertising. Some of the announcers are getting pretty bold about it; they say, "This is the drug your physician uses—this drug is recommended by your family doctor." Doctor Parran specifically refers to a statement that a certain medication should be taken every morning and evening by all those over the age of thirty-five. The new Congress will do well to give such matters very careful attention.

Toner Overley, manager of the Indianapolis Better Business Bureau, tells of still a new scheme to get the money. A letter is sent out asking the recipient to send in one dollar, and in return he will receive a sure-fire method of acquiring all the butter anyone could wish. The dollar brings a printed statement to the effect that all one has to do is to buy some cream and churn it! Reminds us of a similar scheme, many years ago, one that brought a considerable number of dollars to the originator. He advertised a cheap, effectual method of getting rid of potato bugs, and that this information could be had at the cost of one dollar. The sucker soon received two small pieces of wood, with elaborate instructions as to their use. Catch the bug, place it on one of the blocks, place the second block atop this, and "sqush" it. Then you have a dead bug. Seems to us that there is more than one born every minute, these days.

Soon after the first of the year we will be able to give you some definite figures re the cost of getting out your magazine. As everyone knows, the cost of everything has gone up, and this is true in the printing and publishing trade, as well as in all lines. Then, too, there has been a marked increase in the cost of paper stock, which materially adds to our total costs. Your JOURNAL never has skimped on quality—we use the best paper stock to be had, we have one of the best printing firms in the country doing our work, and—bragging a bit—we believe we are getting out a "tops" magazine, whatever the costs may be. We expect to have these figures at an early date and will be glad to give them to you.

Along in the latter part of the summer we were quite concerned about the commercial tomato crop all over our State, when along came the rains, good growing weather, and all that goes to make good tomatoes. So it is that Indiana continues to hold the lead in the production of this succulent fruit—or is it a vegetable? There are claimants for both of these titles. And Indiana tomatoes—whether it be the canned variety, the tomato juice, tomato paste, or whatnot—this brand commands the respect of all dealers and consumers.

Over a thousand Hoosier farmers joined up in a party to attend the National Farm gathering, out in San Francisco. They occupied four special trains—Pullmans, if you please—and made all the stopovers. We are indebted to Maurice Early, one of the best newspaper columnists in the country, for a daily story about this trip. We are indeed glad to know that farmer folk, after many years of being tied down to the homestead, are able to make such a trip. Years ago, back in our Wild Cat days, we never heard of such things; the average farmer confined his trips to an annual visit to a circus, a trip to the county fair, and, on rare occasions, he made the Indiana State Fair—at least a few of them did. In between, he managed to attend the "Old Settlers," at Delphi, and the Cutler and the Burlington Sunday School Picnics. That was just about all of his yearly travels. Vacations, of course, were unheard of, save for the monthly seining party in Wild Cat Creek. The Indiana farmer has come a long way these past few years; he has mechanized his farm holdings, thus lightening his labors and enabling him to cultivate more land, and in later years he has received at least a fair price for his crops. Nothing surprises us about Indiana farmers, any more, they continually are doing the unexpected—doing things they long have wanted to do, but just never got around to. It would not be at all surprising if, in years to come, their "Co-Ops" would erect mammoth hotels in the southern resort sections of the country and arrange for winter vacations for their members, **at a reasonable price!**

President's Page

Sincere greetings for a happy and a prosperous New Year to each and every one of you. And, but not parenthetically, let us rededicate our every effort in 1947 so that the Indiana State Medical Association, your baby and my step-child, may continue to grow and prosper in its organized strength during the year.

This page, of necessity, must be written sixty days before it reaches you. It would, therefore, be most easy to make it a historical chronicle of past events, but such shall not be my purpose. I am not a historian. History, according to Stephen Leacock, consists of the mass of human intelligence drawing the cart upon which rides the professor looking backward and explaining the scenery. I am not a college professor.

Interpreted in the above light, history is but a vestigial appendix to human knowledge, unless we can make it functional, and the true function of history is to teach us to foresee the future by reading the lessons of the past. When any individual or any group of individnals, under identical pressures and counterpressures, always has responded in an identical manner in the past, then even the most dullard reasonably can expect an identical response in the future.

The lesson is obvious! Especially as applies to political-type legislation.

The year 1947 is a legislative year, both at the state and at the national levels. In Indiana Medicine new officers will guide the destiny of every county society. New committees will function. May their choice be carefully made, especially with reference to legislative committees which will have important work to do. "A punt, a pass, and a prayer" will be poor strategy on our part. Basic fundamentals must be stressed. Let us not fumble the ball now in our possession before crossing goal for score.

Floyd L. Romberger

P. S. Keep this number of your JOURNAL handy for ready reference during 1947; it well may be worth to you each month many times the amount of your annual state dues.

A.M.A. HOUSE OF DELEGATES ESTABLISHES PUBLIC RELATIONS DEPARTMENT

F. S. CROCKETT, M.D.

LAFAYETTE

A department of public relations was established within the American Medical Association by action of the House of Delegates at its three-day session in December.

The purpose of this department principally will be to keep the public informed on achievements of medical science, and of the advancement of medical service. Charles Swart, of Philadelphia, a public relations expert, is head of the department. He is executive assistant to Dr. George F. Lull, secretary and general manager of the American Medical Association.

In creating the public relations department the delegates adopted a recommendation made by Raymond Rich Associates, a nationally-known public relations counsel engaged by the A.M.A. Board of Trustees about a year ago to study and report on the association's organization.

The Rich report provoked considerable discussion, particularly that section which dealt with the activities of the National Physicians' Committee. The delegates ordered further study by Mr. Rich of the National Physicians' Committee. The subject will come before the House again at Atlantic City in June.

Copies of the entire controversial Rich report, only parts of which were given out at San Francisco last July, were given to all of the delegates.

In addition to the inauguration of the public relations program, of widespread interest is the position taken by the House of Delegates upon the question of staff appointments to hospitals. The house adopted the following resolution:

> "Resolved, that hospitals should be encouraged to establish general practitioner services. Appointment to a general practice section shall be made by the hospital authorities upon the merits and training of the doctor. Such a general practice section shall not 'per se' prevent approval of a hospital for the training of interns and residencies. The criterion of whether a doctor may be a member of a hospital staff should not be dependent upon certification by the various specialty boards or membership in special societies."

Copies of this resolution were ordered sent to the American College of Surgeons, the American College of Physicians, the American Hospital Association, the Catholic Hospital Association, and all hospitals in the United States.

The House went on record as favoring the extension of the Woman's Auxiliary and directed the A.M.A. Board of Trustees to outline a program and assist in increasing the Auxiliary's activities.

Two resolutions were introduced by the Indiana delegation. One, authored by Dr. Homer G. Hamer, of Indianapolis, would require the American Medical Association to sponsor a national conference of officers of county medical societies yearly. The conference would be similar in nature to the Secretaries' Conference held annually in Indiana. The other resolution was written by Dr. A. S. Giordano, of South Bend. It would establish a reasonable and uniform maximum figure for the remuneration of interns and residents so that "monetary value of internships and residencies may not act as a deciding factor in the applicants for such training."

Doctor Hamer's resolution was referred to the Board of Trustees for study and action. Doctor Giordano's resolution was sent to the Council on Medical Education and Hospitals for study.

Two of the Indiana delegates were appointed as members of Reference Committees. Dr. Don F. Cameron, of Fort Wayne, was named chairman of the Committee on Public Health, and Doctor Giordano was appointed to the Committee on Medical Education and Hospitals.

Dr. R. L. Sensenich, of South Bend, chairman of the Board of Trustees, and the writer, who is chairman of the Committee on Rural Medical Care, submitted reports on the activities of their respective bodies to the House.

Space does not permit a detailed discussion of all actions of the House of Delegates. Those wishing to get further information are urged to read the past three or four A.M.A. Journals, and those coming out during January, which are carrying the complete proceedings in installments.

Hoosiers attending the House sessions, in addition to those already mentioned, were Dr. Karl R. Ruddell, of Indianapolis, alternate delegate; Dr. Cleon A. Nafe, of Indianapolis, president-elect of the Indiana State Medical Association; Dr. A. M. Mitchell, of Terre Haute, alternate delegate and chairman of the Council; Dr. Carl H. McCaskey, of Indianapolis, member of the executive committee; and Ray E. Smith, executive secretary.

SECRETARIES' CONFERENCE

RILEY ROOM, CLAYPOOL HOTEL
INDIANAPOLIS
SUNDAY, JANUARY 12, 1947

1:30 p.m. Call to order and opening remarks by A. M. MITCHELL, M.D., Terre Haute, Chairman.

1:35 p.m. Welcome to secretaries by CLEON A. NAFE, M.D., Indianapolis, President-elect, Indiana State Medical Association.

1:45 p.m. Report on AMA House of Delegates by H. G. HAMER, M.D., Indianapolis, a delegate from Indiana State Medical Association.

2:00 p.m. *The Legislative Program of the State Board of Health* by L. E. BURNEY, M.D., Indianapolis, State Health Commissioner.

2:15 p.m. *Medical Legislation* by NORMAN M. BEATTY, M.D., Indianapolis, Co-chairman, Committee on Public Policy and Legislation, Indiana State Medical Association.

Discussion by J. WILLIAM WRIGHT, M.D., Indianapolis, Co-chairman, Committee on Public Policy and Legislation, Indiana State Medical Association.

2:45 p.m. *The Veterans' Care Program* by CHARLES F. THOMPSON, M.D., Indianapolis, Chairman, Veterans' Care Committee, Indiana State Medical Association.

3:00 p.m. Intermission.

3:10 p.m. *Public Relations* by J. S. DE TAR, M.D., Milan, Michigan, Chairman of the Public Relations Committee, Michigan State Medical Society.

3:30 p.m. *Mutual Medical Insurance, Inc.*, by WALTER U. KENNEDY, M.D., New Castle, President, Mutual Medical Insurance, Inc.

3:45 p.m. *THE JOURNAL* by E. M. SHANKLIN, M.D., Hammond, Editor.

4:00 p.m. *Auxiliary Membership Plans* by Mrs. S. J. Petronella, East Chicago, President, Woman's Auxiliary to the Indiana State Medical Association.

4:15 p.m. *The Nurse Shortage* by Miss E. Nancy Scramlin, Muncie, President, Indiana State Nurses Association.

4:45 p.m. *The Rural Medical Care Program in Indiana* by H. N. SMITH, M.D., Brookville, Chairman, Committee on Rural Medical Care.

Election of chairman for 1947, and adjournment.

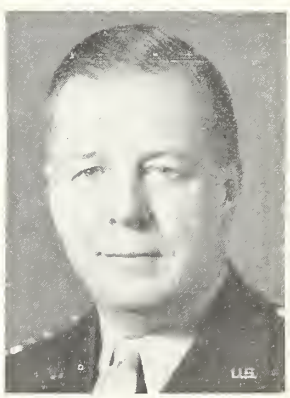
6:00 p.m. Dinner, Riley Room, Claypool Hotel.

Speakers: FLOYD T. ROMBERGER, M.D., Lafayette, President, Indiana State Medical Association.

Subject: *Your County Society.*

GEORGE F. LULL, M.D., Chicago, Secretary and General Manager, American Medical Association.

Subject: *American Medicine Looks to the Future.*



Dr. George F. Lull

All Members of the Indiana State Medical Association are Cordially Invited and Urged to Hear this Fine Program

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of the members of the Indiana State Medical Association, including the names of all those who were members on November 30, 1946. Membership established after that date could not be included in this issue of THE JOURNAL. Members are listed in the county in which they hold their membership.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

Name	City	County
Aagesen, J. W.	Anderson	Madison
Abel, J. A.	South Bend	St. Joseph
Abel, Virgil	Vallonia	Jackson
Abell, Charles F.	Marion	Grant
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B.	South Bend	St. Joseph
Aere, R. R.	Evansville	Vanderburgh
Adair, Samuel L.	Jeffersonville	Clark
Adair, Wm. K.	Crothersville	Jackson
Adams, C. J.	Kokomo	Howard
Adams, J. R.	Fort Wayne	Allen
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Ade, C. H.	La Fayette	Tippecanoe
Ade, Mary	La Fayette	Tippecanoe
Adkins, H. C.	Indianapolis	Marion
Adkins, Onan C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew
Adler, Edmund R.	Dyer	Lake
Adler, Raymond N.	Evansville	Vanderburgh
Aiken, Milo M.	Plainfield	Hendricks
Aiken, N. E.	Fort Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Aker, Charles L.	Greencastle	Putnam
Albertson, F. P.	Indianapolis	Marion
Albrecht, J. R.	Vincennes	Knox
Albright, Victor F.	Indianapolis	Marion
Alburger, Henry R.	Indianapolis	Marion
Aldrich, Harry	Fort Wayne	Allen
Aldrich, Harry	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Aldridge, J. W.	Covington	Fountain-Warren
Alexander, H. H.	Princeton	Gibson
Alexander, J. E.	Evansville	Vanderburgh
Alexander, J. M.	Highland Park, Ill.	Marshall
Alexander, O. O.	Terre Haute	Vigo
Alexander, P. M.	Martinsville	Morgan
Alexander, W. P. (H)	Gary	Lake
Allen, Fred K.	Salem	Washington
Allen, Hubert E.	Richmond	Wayne-Union
Allen, J. L.	Greenfield	Hancock
Allen, Loniel H.	Bedford	Lawrence
Allen, Orris T.	Terre Haute	Vigo
Allen, Robert T.	Richmond	Wayne-Union
Allenbaugh, A. E.	Evansville	Vanderburgh
Almquist, C. O.	Gary	Lake
Altier, W. H.	Fowler	Benton
Alvis, Edmond O.	Indianapolis	Marion
Alward, John Haney	Akron, Ohio	Marion
Ambrose, J. C.	Noblesville	Hamilton
Ames, George (H.)	Eaton	Delaware-Blackford
Amick, Charles L.	Wakarusa	Elkhart
Amos, R. L.	New Castle	Henry
Amy, W. E.	Corydon	Harrison
Anderson, Charles P.	Gary	Lake
Anderson, D. W.	Evansville	Vanderburgh
Anderson, R. J.	Indianapolis	Marion
Anderson, R. M.	Vincennes	Knox
Anderson, Walter C.	Terre Haute	Vigo
Anderson, W. C.	Valparaiso	Porter
Andrews, C. L.	Bethesda, Md.	Hancock
Andrews, D. Lee	Louisville, Ky.	Marion
Annis, Homer B.	Bluffton	Wells
Antes, Earl H.	Evansville	Vanderburgh
Anthoulis, George D.	Gary	Lake
Appel, R. H.	Indianapolis	Marion
Applegate, A. Earl	Frankfort	Tippecanoe
Applegate, F. M.	Corydon	Harrison
Arbogast, John L.	Indianapolis	Tippecanoe
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, Russell	Indianapolis	Marion
Arbuckle, Wm. E.	Indianapolis	Marion
Arford, R. D.	Middletown	Henry
Arisman, R. K.	South Bend	St. Joseph
Arlook, Theodore D.	Elkhart	Elkhart
Armington, C. L.	Anderson	Madison
Armington, John C.	Anderson	Madison
Armington, Robert	Anderson	Madison
Armstrong, T. D.	Michigan City	La Porte
Arnett, A. C.	La Fayette	Tippecanoe
Arnold, Aaron L.	Indianapolis	Marion
Arnold, Marion F., Jr.	East Chicago	Lake
Arnold, Ralph D.	Sheridan, Wyo.	Noble
Arnold, Ralph N.	Greenfield	Hancock
Aronson, Sidney S.	Indianapolis	Marion
Arthur, H. M.	Hazelton	Gibson
Arthur, N. Maude	Washington	Daviess-Martin
Asbury, W. D.	Terre Haute	Vigo
Ash, H. H.	West Lafayette	Tippecanoe
Asher, E. O.	New Augusta	Marion
Asher, James W.	New Augusta	Marion
Ashworth, L. N.	Connersville	Fayette-Franklin
Atchison, K. C.	Rockport	Spencer
Atkins, C. C.	Rushville	Rush
Atkinson, C. W.	Boswell	Benton
Aucreman, C. J.	Cleveland, Ohio	Delaware-Blackford
Austin, Eugene W.	Indianapolis	Madison
Austin, F. H. (H)	Bloomington	Owen-Monroe
Austin, M. A.	Anderson	Madison
Austin, R. P.	Bedford	Lawrence
Ayres, Kenneth D.	Anderson	Madison
Ayres, W. W.	Marion	Grant
Baehmann, Arnold J.	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois
Badders, A. C.	Portland	Jay
Baganz, C. N.	Little Rock, Ark.	Wells
Bahr, Max A.	Indianapolis	Marion
Bailey, A. L.	Michigan City	La Porte
Bailey, Edwin B.	Linton	Greene
Bailey, E. W.	Logansport	Cass
Bailey, L. S.	Zionsville	Boone
Bailey, Paul P.	Fort Wayne	Allen
Bailey, Perry W.	Claremont, Calif.	Allen
Bailey, W. A.	Vincennes	Knox
Baitinger, H. M.	Gary	Lake
Bakemeier, O. H.	Indianapolis	Marion
Baker, A. M.	New Albany	Floyd
Baker, C. S.	Evansville	Vanderburgh
Baker, G. D.	Crandall	Harrison
Baker, Herman	Evansville	Vanderburgh
Baker, J. S.	Evansville	Vanderburgh
Baker, Leslie M.	Indianapolis	Delaware-Blackford
Baker, Milan D.	Culver	Marshall
Baker, Robert E. (H)	Orleans	Orange
Baker, Warren	Michigan City	La Porte
Baker, W. H.	South Bend	St. Joseph
Balch, James F.	Indianapolis	Marion
Baldridge, E. R.	Terre Haute	Vigo
Baldridge, W. O.	Terre Haute	Vigo
Baldwin, John H.	Jeffersonville	Clark
Ball, Clay A.	Muncie	Delaware-Blackford
Ball, Joseph E.	Indianapolis	Marion
Ball, Thomas Z. (H)	Crawfordsville	Montgomery
Balla, Morris	South Bend	St. Joseph
Ballard, C. A.	Logansport	Cass
Ballard, Robert J.	Lebanon	Boone
Ballenger, W. E.	Richmond	Wayne-Union
Balsbaugh, George	N. Manchester	Wabash
Baltes, Joseph H.	Fort Wayne	Allen
Banister, R. F.	Indianapolis	Marion
Bankoff, Milton L.	Michigan City	La Porte
Banks, H. M.	Indianapolis	Marion
Baran, Charles, Jr.	Gary	Lake
Barclay, I. C.	Evansville	Vanderburgh

Name	City	County
Bard, Frank B.	Crothersville	Jackson
Barnard, P. C. (H)	Parker	Delaware-Blackford
Barnes, Helen B.	Greenwood	Marion
Barnett, Ernest R.	Indianapolis	Marion
Barnett, R. E.	Peru	Miami
Barnett, Wm.	Dallas, Texas	Cass
Barnum, Emerson	Shelbyville	Shelby
Barrett, D. C.	Columbus	Bartholomew
Barrow, John H.	Dale	Spencer
Barry, M. J.	Indianapolis	Marion
Bartholomew, A. C.	Fort Wayne	Allen
Bartholomew, Mary	Goshen	Elkhart
Bartle, J. Leo	Indianapolis	Henry
Bartlett, Robert C.	Dublin	Wayne-Union
Bartley, Max D.	Indianapolis	Marion
Barton, W. M.	Centerville	Wayne-Union
Baskett, R. J.	Jonesboro	Grant
Bass, F. E.	Shelbyville	Shelby
Bassett, Clancy	Thorntown	Boone
Bassett, Margaret	Thorntown	Owen-Monroe
Bassler, C. R.	Mishawaka	St. Joseph
Batman, Gordon W.	Indianapolis	Marion
Battersby, J. Stanley	Indianapolis	Marion
Bauer, A. J.	La Fayette	Tippecanoe
Bauer, Thomas B.	Indianapolis	Marion
Baumgart, E. T.	Danville, Ill.	Marion
Baumgartner, Jeraldine	Fort Wayne	Allen
Baumrucker, G. O.	Oak Park, Ill.	Marion
Baxter, J. W., Jr.	New Albany	Floyd
Baxter, Neal	Bloomington	Owen-Monroe
Baxter, Samuel M.	New Albany	Floyd
Bayley, R. H.	La Fayette	Tippecanoe
Beach, Robert R.	Indianapolis	Marion
Beamer, G. D.	Dearborn, Mich.	Carroll
Beams, Ralph H.	Indianapolis	Grant
Bear, L. H. (H)	Vevay	Switzerland
Beardsley, Frank A.	Frankfort	Clinton
Beardsley, Oliver B.	South Bend	St. Joseph
Beasley, T. J.	Indianapolis	Marion
Beatty, Norman M.	Indianapolis	Marion
Beaver, Ernest R.	Rensselaer	Marion
Beaver, Howard W.	Indianapolis	Marion
Bechtold, S. E.	South Bend	St. Joseph
Beek, Evart M.	Indianapolis	Marion
Beck, H. A.	Lebanon	Boone
Becker, Philip H.	Crown Point	Lake
Beckes, Ellsworth	Vincennes	Knox
Beekman, H. F.	Indianapolis	Marion
Bedwell, Marion H.	Sullivan	Sullivan
Beeler, Bruce H.	Evansville	Vanderburgh
Beeler, John W.	Indianapolis	Marion
Beeler, Raymond C.	Indianapolis	Marion
Beetem, L. F.	Madison	Jefferson
Beggs, L. F.	Columbus	Bartholomew-Brown
Behn, Walter M.	Gary	Lake
Beierlein, Karl	Fort Wayne	Allen
Belden, L. D.	Indianapolis	Marion
Benchik, Frank A.	East Chicago	Lake
Bender, Cecil K.	Goshen	Elkhart
Bender, Robert L.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake
Benham, James W. (H)	Columbus	Bartholomew-Brown
Bennett, J. B.	Warren	Huntington
Benninghoff, D. R.	Fort Wayne	Allen
Benz, Jesse	Marengo	Crawford
Benz, O. F.	Wanatah	Lake
Beresford, G. B. (H)	Owensville	Gibson
Berger, Henry I.	Indianapolis	Marion
Berghoff, Raymond	Fort Wayne	Allen
Berke, Robert	South Bend	St. Joseph
Berkebile, J. B.	Peru	Miami
Berman, Jacob K.	Indianapolis	Marion
Bernheimer, H. L. (H)	Terre Haute	Vigo
Bernoske, D. G.	Michigan City	La Porte
Berns, P. C.	Linton	Greene
Bernstein, Joseph	New York City	Marion
Bethea, Dennis A.	Hammond	Lake
Beverland, M. E.	Indianapolis	Marion
Bibler, Henry E.	Muncie	Delaware-Blackford
Bibler, L. D.	Indianapolis	Marion
Bickel, David A.	South Bend	St. Joseph
Bickel, J. E.	Fort Wayne	Allen
Bicknell, G. F.	East Chicago	Lake
Bierly, Fred	Elizabeth	Floyd
Bigelow, O. P.	Roanoke	Huntington
Bigham, J. C.	Batesville	Ripley
Bill, Robert O.	San Diego, Calif.	Marion
Billman, Gustus S.	Shelbyville	Shelby
Bills, L. F.	Gary	Lake
Bills, R. N.	Gary	Lake
Bird, Charles R.	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birmingham, P. J.	South Bend	St. Joseph
Bishop, Charles A.	South Bend	St. Joseph
Bitler, C. C.	New Castle	Henry
Bixler, Louis C.	South Bend	St. Joseph
Bizer, Mier A.	Jeffersonville	Clark
Black, Claude S.	Warren	Huntington
Black, Edgar K.	Wabash	Wabash
Blackburn, Erwin	South Bend	St. Joseph
Blackford, Florence	Indianapolis	Marion
Blackford, Ralph E.	Indianapolis	Marion
Blackford, Roger W.	Indianapolis	Marion
Blackstone, Jack C.	Nashville, Tenn.	Marion
Blaize, J. L.	New Castle	Knox
Bland, Curtis	Oaktown	Vigo
Bland, H. E.	Fairhanks	Sullivan
Blatt, A. E.	Indianapolis	Marion
Blazey, A. G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Henry
Blemker, Russell	Greensburg	Decatur
Blessinger, Paul J.	Jasper	Dubois
Bloemker, E. F.	Indianapolis	Marion
Bloom, Asa Ward	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, J. R.	Rockville	Parke-Vermillion
Bloomer, R. S.	Rockville	Parke-Vermillion
Blosser, B. A.	Fremont	Steuben
Blosser, H. V.	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl	Gary	Lake
Boaz, John J.	Indianapolis	Marion
Boerger, Victor L.	Fort Wayne	Allen
Bogardus, C. R.	Austin	Scott
Boggs, E. F.	Indianapolis	Marion
Bohner, C. B.	Indianapolis	Marion
Bolin, John T.	Hammond	Lake
Bolin, Robert S.	Elkhart	Elkhart
Boling, R. L.	St. Petersburg, Fla.	Marion
Bolka, B. J.	South Bend	St. Joseph
Bolman, R. Morton	Fort Wayne	Allen
Bonaventura, A. P.	East Chicago	Lake
Bond, Charles S. (H)	Richmond	Wayne-Union
Bond, George S.	Indianapolis	Marion
Bond, Walter	Clay City	Clay
Boner, G. W.	No. Madison	Jefferson
Bonifield, H. F.	Warren	Huntington
Booher, Irvin E.	Connersville	Fayette-Franklin
Booher, Norman R.	Indianapolis	Marion
Booher, Olga	Indianapolis	Marion
Boone, John C. (H)	South Bend	St. Joseph
Bopp, D. W.	Whiting	Lake
Bopp, Henry W.	Terre Haute	Vigo
Borders, Theo. R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (H)	Poseyville	Posey
Borland, R. M.	Bloomington	Owen-Monroe
Bosenbury, C. S.	South Bend	St. Joseph
Boswell, Robert W.	Hammond	Lake
Bothwell, C. G.	Martinsville	Morgan
Bottorff, David C.	Charlestown	Clark
Boughman, Joseph D.	Kokomo	Howard
Boulware, J. P.	Bloomington	Monroe
Bounell, E. G.	Hillsboro	Fountain-Warren
Bourke, William	Fort Meade, S. D.	Grant
Bowdoin, G. E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bowers, Copeland C.	Kokomo	Howard
Bowers, Don D.	Indianapolis	Marion
Bowers, G. T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, John A.	Kokomo	Howard
Bowers, J. W.	Fort Wayne	Allen
Bowles, J. H.	Muncie	Delaware-Blackford
Bowman, Charles M.	Albion	Noble
Bowman, George W.	Indianapolis	Marion
Bown, Albert J.	Indianapolis	Marion
Boyd, C. L.	Vincennes	Knox
Boyd, Charles S.	East Chicago	Lake
Boyd, Clarence E.	West Baden	Orange
Boyd, David A., Jr.	Indianapolis	Marion
Boyd, Nelson E.	Freelandville	Knox
Boyd, Stella N	Evansville	Vanderburgh
Boyd-Snee, Harry (H)	Los Angeles, Calif.	St. Joseph
Boyer, E. B.	Indianapolis	Marion
Boyer, Floyd A	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boys, Floyd E.	Indianapolis	Marion
Boys, F. F.	East Chicago	Lake
Bradfield, John C.	Logansport	Cass
Bradley, Stephen C.	Terre Haute	Vigo
Brady, Samuel	Gary	Lake
Braginton, Fred (H)	Hammond	Marion
Brandman, Harry	Whiting	Lake
Brauchla, C. H.	Anderson	Madison
Braner, A. A.	East Chicago	Lake
Braun, Benjamin D.	East Chicago	Lake
Braunlin, Robert F.	Marion	Grant
Braunlin, W. H.	Marion	Grant
Braunsdorf, R. L.	South Bend	St. Joseph
Brayton, John R.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brazelton, O. T	Princeton	Gibson
Brenner, Andrew M.	Winchester	Randolph
Brenner, I. E.	Winchester	Randolph
Bretz, W. D.	Huntingburg	Dubois
Brickley, H. D	Bluffton	Wells
Bridwell, Edgar	Bedford	Carroll
Briggs, Carl F.	Sullivan	Sullivan
Briggs, J. H.	Churubusco	Whitley
Brill, I. William	Ann Arbor, Mich.	Marion
Briscoe, C. E.	New Albany	Floyd
Britton, W. D.	Montezuma	Marion
Brock, Earl E.	Anderson	Madison
Brodie, Donald W.	Indianapolis	Marion
Brody, Arthur	Hollywood, Calif.	Lake
Bronson, Paul J.	Terre Haute	Vigo
Brookie, Roger W.	Battle Creek, Mich.	Carroll
Brooks, H. L.	Michigan City	La Porte
Broomes, Edward L. C.	East Chicago	Lake
Brosius, Robert H. W.	Fort Wayne	Allen
Brother, Geo. M.	Indianapolis	Marion
Brown, A. E.	Indianapolis	Marion
Brown, D. B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, Dewitt W.	New Augusta	Marion
Brown, Edward A.	Indianapolis	Marion
Brown, Frances T.	Indianapolis	Marion
Brown, George E.	Greenwood	Johnson
Brown, Harry M.	Indianapolis	Marion
Brown, James C.	Valparaiso	Porter
Brown, J. S.	Carlisle	Sullivan
Brown, Karl T.	Muncie	Delaware-Blackford
Brown, K. H.	New Albany	Floyd
Brown, Leland G.	Indianapolis	Marion
Brown, M. S.	Spencer	Owen-Monroe
Brown, R. E.	Cayuga	Parke-Vermillion
Brown, Robert L.	Evansville	Vanderburgh
Brown, Robert R.	Terre Haute	Vigo
Brown, Robert M.	Marion	Grant
Brown, Stanley L.	Hammond	Lake
Brown, Wendell E.	Indianapolis	Marion
Browning, J. S.	Indianapolis	Marion

Name	City	County
Browning, W. M.	Indianapolis	Marion
Brubaker, E. H. (H)	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubaker, O. G.	N. Manchester	Wabash
Bruegge, T. J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruggeman, H. O.	Fort Wayne	Allen
Bruner, C. H.	Greenfield	Hancock
Bruner, Ralph	Jeffersonville	Clark
Bryan, F. A.	Indlanapolis	Marion
Bryan, S. L.	Evansville	Vanderburgh
Buchanan, W. D.	South Bend	St. Joseph
Buche, F. P.	Richmond	Wayne-Union
Buckingham, Richard	Bloomington	Monroe
Buckley, E. P.	Jeffersonville	Clark
Buckner, Doster	Fort Wayne	Allen
Buckner, Joy F.	Bluffton	Wabash
Buechner, F. W.	South Bend	St. Joseph
Buehl, Robert F.	Indianapolis	Marion
Buhrmester, H. C.	La Fayette	Tippecanoe
Buikstra, C. R.	Evansville	Vanderburgh
Bullard, Mattie J.	Casselton,N.D.	Lake
Bulson, Eugene L.	Fort Wayne	Allen
Bunch, Rollin H.	Muncie	Delaware-Blackford
Bundy, Chester Merle	Indianapolis	Washington
Bunker, L. Z.	N. Manchester	Wabash
Burcham, J. B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burge, A. D.	Marion	Grant
Burk, James M.	Decatur	Adams
Burke, Homer L.	Castaner, Puerto Rico	Marshall
Burkhardt, B. A.	Tipton	Tipton
Burkle, J. C.	La Fayette	Tippecanoe
Burman, Richard G.	Jeffersonville	Clark
Burnett, Arthur B.	New Castle	Henry
Burney, Leroy E.	Indianapolis	Marion
Burns, Elizabeth (H)	Fort Wayne	Allen
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, B. O.	Washington	Daviess-Martin
Burris, F. L.	Michigan City	La Porte
Burroughs, C. A.	Frankfort	Clinton
Burrous, E. Lee	Peru	Miami
Burton, F. H.	Butte, Mont.	Marion
Bush, Hargis R.	Cannelton	Perry
Bussard, C. F.	South Bend	St. Joseph
Butler, Raymond	Beech Grove	Marion
Butman, W. C.	Hebron	Porter
Butterfield, Robt. M.	Muncie	Delaware-Blackford
Buttz, Rose J.	Indianapolis	Marion
Byers, Norman R.	Bedford	Lawrence
Byrn, H. W.	New Albany	Floyd
Byrne, Basil	New Albany	Floyd
Byrne, Robert J.	Bicknell	Knox
Cabell, A. L. (H)	Terre Haute	Vigo
Cacia, John J.	Evansville	Vanderburgh
Cahal, E. E.	Indianapolis	Marion
Cahn, Hugo M.	Indlanapolis	Marion
Caldwell, William C.	Evansville	Vanderburgh
Call, E. B	Knightstown	Henry
Call, H. F.	Indianapolis	Marion
Callaghan, W. C.	Greensburg	Decatur
Callahan, R. H.	East Chicago	Lake
Calvert, R. R.	La Fayette	Tippecanoe
Calvin, Jessie C. (H)	Fort Wayne	Allen
Calvy, William J.	Indianapolis	Marion
Cameron, D. F.	Fort Wayne	Allen
Campagna, E. A.	East Chicago	Lake
Campbell, J. A.	Indianapolis	Marion
Campbell, P. A.	Richmond	Wayne-Union
Campbell, Sam W.	Indianapolis	Marion
Canada, Clement L.	Logansport	Cass
Canaday, C. E.	New Castle	Henry
Canaday, J. W.	Indianapolis	Marion
Caplin, Irvin	Indianapolis	Marion
Caplin, S. S.	Indianapolis	Marion
Carbone, J. A.	Gary	Lake
Carey, W. W. (H)	Fort Wayne	Allen
Carlberg, D. L.	Jeffersonville	Clark
Carleton, E. H.	East Chicago	Lake
Carlo, Ernest R.	Fort Wayne	Allen
Carlo, J. F.	Hammond	Lake
Carlson, E. A.	Peru	Miami
Carlyle, Ivan E.	Michigantown	Clinton
Carmichael, C. S.	Seelyville	Vigo
Carmody, R. F.	Gary	Lake
Carneal, Thomas E.	Winamac	Pulaski
Carney, C. E. (H)	Delphi	Carroll
Carney, J. T.	Jeffersonville	Clark
Carney, John C.	Monticello	Tippecanoe
Carpenter, G. C.	Terre Haute	Vigo
Carpenter, J. L.	Alexandria	Madison
Carpenter, Thomas D.	Columbus	Bartholomew
Carpentier, Harry F.	Princeton	Gibson
Carrel, Francis E.	Frankfort	Clinton
Carroll, John C.	Decatur	Adams
Carson, Wayne	Indianapolis	Marion
Carter, F. R. Nicholas	South Bend	St. Joseph
Carter, James C.	Indianapolis	Marion
Carter, J. V.	Tipton	Tipton
Carter, Oren E.	Indianapolis	Marion
Cartwright, E. L.	Fort Wayne	Allen
Casebeer, P. B.	Clinton	Parke-Vermillion
Caseley, Donald J.	Indianapolis	Marion
Casey, Stanley M.	Huntington	Huntington
Casper, Joseph	Jasper	Dubois
Casper, J. P.	Jasper	Dubois
Cassady, J. V.	South Bend	St. Joseph
Catlett, M. B.	Fort Wayne	Allen
Caton, J. R.	South Bend	St. Joseph
Cavins, A. W.	Terre Haute	Vigo
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Challman, W. B.	Mount Vernon	Posey
Chambers, A. R.	Fort Wayne	Allen
Chambers, L. B.	Union City	Randolph
Chandler, L. H.	Millersburg	Elkhart
Chapin, C. C.	Logansport	Cass
Charles, Etta (H)	Anderson	Madison
Chattin, Herbert O.	Vincennes	Knox
Chattin, V. J.	Washington	Daviess-Martin
Chen, K. K.	Indianapolis	Marion
Cheney, F. D.	Thomasville, Ga.	Marion
Chester, H. R.	Cottonwood, Ariz.	Allen
Chevigny, J. J.	Gary	Lake
Chidlaw, B. W.	Hammond	Lake
Childs, A. G. W.	Madison	Jefferson
Childs, Wallace E.	Fairfield, O.	Gibson
Chittick, A. G.	Frankfort	Clinton
Chrispin, John W.	Bluffton	Wells
Christophel, Verna	Mishawaka	St. Joseph
Clancy, J. F.	Hammond	Lake
Clapp, Fred R.	South Bend	St. Joseph
Clark, C. M.	Oakland City	Gibson
Clark, C. P.	Indlanapolis	Marion
Clark, Cyrus J.	Indianapolis	Marion
Clark, Fred O.	Syracuse	Elkhart
Clark, Ivan A.	Paoli	Orange
Clark, L. J.	Indianapolis	Marion
Clark, M. E.	Cambridge City	Wayne-Union
Clark, Stanley A.	South Bend	St. Joseph
Clark, Wm. H.	South Bend	St. Joseph
Clark, W. R.	Fort Wayne	Allen
Clarke, Elton R.	Kokomo	Howard
Clauser, A. C.	Delphi	Carroll
Clauser, E. H.	Muncie	Delaware-Blackford
Clawson, J. C.	Richmond	Wayne-Union
Clements, A. F.	Evansville	Vanderburgh
Clevenger, J. H.	Muncie	Delaware-Blackford
Clevinger, Wm. G.	Indianapolis	Marion
Cline, George	Logansport	Delaware-Blackford
Close, W. D.	Indianapolis	Marion
Clouse, Paul A.	Indianapolis	Marion
Clunie, Wm. A.	Corydon	Harrison
Coble, F. H.	Richmond	Wayne-Union
Coble, R. R.	Indianapolis	Marion
Cochran, R. B.	Washington	Knox
Cockrum, Wm. M.	Evansville	Vanderburgh
Cody, B. L.	Evansville	Vanderburgh
Coffel, Melvin H.	Vincennes	Knox
Cohen, B. B.	East Chicago	Lake
Cohen, B. W.	Indianapolis	Marion
Cohen, Morris	Louisville, Ky.	Lawrence
Cohn, Phillip	New Albany	Floyd
Cole, A. V.	Hammond	Lake
Cole, Ira	La Fayette	Tippecanoe
Cole, R. E.	Muncie	Delaware-Blackford
Cole, Wm. L.	Evansville	Vanderburgh
Coleman, H. G.	Odon	Daviess-Martin
Coleman, W. H.	Evansville	Vanderburgh
Coleman, Wm. S.	Carthage	Rush
Colglazier, Donald L.	Indianapolis	Marion
Colglazier, G. G.	Leipsic	Orange
Colip, George	South Bend	St. Joseph
Collett, G. A.	Crawfordsville	Montgomery
Collins, Hubert L.	Indianapolis	Marion
Collins, J. N.	Indianapolis	Marion
Combs, Charles N.	Terre Haute	Vigo
Combs, Herman	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Nelson B.	Mulberry	Clinton
Combs, Pearl B.	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comer, Charles W.	Mooresville	Morgan
Comer, J. E.	Mooresville	Morgan
Comer, Kenneth E.	Mooresville	Morgan
Compton, C. B.	Frankfort	Clinton
Compton, Walter A.	Elkhart	Elkhart
Comstock, Glenn E.	Gary	Lake
Condit, David H.	South Bend	St. Joseph
Conger, Elizabeth	Indianapolis	Marion
Congleton, G. C.	Terre Haute	Vigo
Conklin, R. L.	Elkhart	Elkhart
Conley, John E.	Fort Wayne	Allen
Conley, Joseph L.	Indianapolis	Marion
Conley, T. M.	Kokomo	Howard
Connell, P. S.	Plymouth	Marshall
Connell, Vactor O.	Fulton	Fulton
Connelly, J. J.	Terre Haute	Vigo
Conner, T. E.	Freetown	Jackson
Connerley, M. L.	Terre Haute	Marion
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo	Tipton	Tipton
Conover, Earl	Evansville	Vanderburgh
Conrad, E. M.	Anderson	Madison
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapoils	Marion
Cook, C. J. (H)	Indianapolis	Marion
Cook, Charles E.	No. Manchester	Wabash
Cook, E. C.	Madison	Jefferson
Cook, G. M.	Hammond	Lake
Cook, Norman R.	Long Island, N. Y.	Marion
Cook, Robert G.	Bluffton	Wells
Cooksey, Thomas L.	Crawfordsville	Montgomery
Coomes, M. Joseph	Shelbyville	Shelby
Cooney, Charles J.	Fort Wayne	Allen
Coons, John D.	Lebanon	Boone
Cooper, H. L.	South Bend	St. Joseph
Cooper, Leo Kenneth	Gary	Lake
Cooper, Ross A.	Carmel	Hamilton
Cooper, Thomas L.	Logansport	Cass
Copeland, C. C. (H)	North Madison	Jefferson
Copeland, G. W.	Vevay	Switzerland
Copeland, S. J.	Indianapolis	Marion
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, M.	Indianapolis	Marion
Cornell, Beaumont S.	Fort Wayne	Adams
Cortese, Thomas A.	Indianapolis	Marion
Cotter, E. R.	East Chicago	Lake
Cottingham, C. E. (H)	Indianapolis	Marion
Cotton, Perry	Elwood	Madison
Cotton, S. M.	Goldsmith	Tipton
Coulson, S. B.	Waldron	Shelby
Coultas, P. J.	Tell City	Perry
Covalt, Donald A.	Washington, D. C.	Delaware-Blackford
Covalt, Nila	Washington, D. C.	Delaware-Blackford
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, H. M.	Auburn	De Kalb
Cox, C. E.	Indianapolis	Marion

Name	City	County
Cox, H. Bailey	Indianapolis	Marion
Cox, Leon T.	Richmond	Wayne-Union
Cox, W. T.	La Fayette	Tippecanoe
Coyner, A. B.	La Fayette	Tippecanoe
Craft, K. L.	Indlanapolis	Marion
Craft, William F.	Linton	Greene
Craig, Alexander F.	Knightstown	Marion
Craig, R. A.	Kokomo	Howard
Craig, Robert A.	Syracuse	Marion
Cramp, Arthur J. (H)	Hendersonville, N. C.	Porter
Crampton, C. C.	Delphi	Carroll
Crane, Albert L.	Evansville	Vanderburgh
Crawford, W. G.	Terre Haute	Vigo
Creel, Donald	Angola	Steuben
Crimm, Paul D.	Evansville	Vanderburgh
Crlng, George	Portland	Jay
Cripe, E. P.	Bremen	Marshall
Crockett, F. S.	La Fayette	Tippecanoe
Crossland, Steward H.	Gary	Lake
Crowder, James H., Jr.	Sullivan	Sullivan
Crum, Marion M.	Angola	Steuben
Culbertson, C. S.	Soutb Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, P. K.	Indianapolis	Marion
Cullnane, C. W.	Evansvllle	Vanderburgh
Culmer, W. N.	Bloomington	Owen-Monroe
Culp, John E.	Fort Wayne	Allen
Cummings, D. J.	Brownstown	Jackson
Cunningham, J. M.	Indlanapolis	Marlon
Cure, Elmer T.	Muncle	Delaware-Blackford
Curry, Claude A.	Terre Haute	Vlgo
Curtncr, M. L.	Vlncennes	Knox
Cushman, J. B.	Gary	Lake
Custer, E. W.	South Bend	St. Joseph
Cuthbert, F. S.	Kokomo	Howard
Cuthbert, M. P.	Indianapolis	Howard
Dahling, C. W.	New Haven	Allen
Dailey, J. E.	Terre Haute	Vlgo
Dainko, A. J.	Whiting	Lake
Dale, J. W.	Chesterton	Porter
Dalton, John E.	Indlanapolls	Marlon
Dalton, Naoml	Bloomington	Owen-Monroe
Dancer, C. R.	Fort Wayne	Allen
Dando, George H.	Hartford City	Delaware-Blackford
Danlel, J. C.	Indianapolis	Marion
Danieleskl, L. J.	Gary	Lake
Daniels, E. O.	Marion	Grant
Daniels, G. R.	Marion	Grant
Danruther, C. B.	La Porte	La Porte
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy	Evanston, Ill.	St. Joseph
Darroch, S. C.	Cayuga	Parke-Vermillion
Daubenheyer, M. F.	Butlerville	Ripley
Daugherty, F. N.	Crawfordsville	Montgomery
Daves, W. L.	Evansville	Vanderburgh
Davidoff, Manuel A.	Ossian	Wells
Davidson, N. Cort	Indianapolis	Marion
Davidson, Wm. D.	Evansville	Vanderburgh
Davidson, W. R.	Evansville	Vanderburgh
Davis, Alice H.	Hammond	Lake
Davis, Carl M.	Valparaiso	Porter
Davis, D. F.	New Albany	Floyd
Davis, E. C.	Muncie	Delaware-Blackford
Davis, George D.	Rochester, Minn.	Marion
Davis, George H.	Union City	Randolph
Davis, J. A.	Flat Rock	Shelby
Davis, John A.	Indianapolis	Marion
Davis, J. M.	Indlanapolis	Marion
Davis, John C.	Logansport	Cass
Davis, Joseph B.	Marion	Grant
Davis, L. H.	Mentone	Kosciusko
Davis, M. S.	Marlon	Grant
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Neal	Lowell	Lake
Davis, Parvin M.	New Albany	Floyd
Davis, Richard	Marion	Grant
Davis, Sam J.	Indianapolis	Marion
Davisson, C. V.	Williamsport	Fountain-Warren
Day, C. W.	Indianapolis	Marion
Day, George H.	New Albany	Floyd
Day, John	Indianapolis	Marion
Day, W. D. C.	Seymour	Jackson
Deal, Eleanor H.	Speedway City,	Marion
Dean, Donald I.	Rushville	Rush
Dean, Michael F.	Indianapolis	Marion
Deardorff, O. M.	Muncie	Delaware-Blackford
Dearmin, R. M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
Decker, H. B.	Terre Haute	Vlgo
DeDario, L. M.	Elkhart	Elkhart
Deen, H. H.	Leavenworth	Crawford
Deer, Blan F.	Indianapolis	Marion
Deever, J. W.	Indianapolis	Marion
DeFries, John J.	Muncie	Delaware-Blackford
DeGrazia, E. J.	Valparaiso	Porter
DeLawter, Hilbert H.	Topeka, Kans.	Marion
De Lawter, Pierre	Long Beach, Calif.	Marion
DeLong, C. A.	Gary	Lake
DeLong, O. A. (H)	Elizabethtown	Bartholomew-Brown
De Motte, C. Bowen	Indianapolis	Marion
DeMotte, Russell A.	Bloomington	Owen-Monroe
DeNaut, J. F.	Knox	Starke
DeNaut, J. L.	Hamlet	Starke
Denman, R. D.	Helmer	Steuben
Denny, Edgar C.	Richmond	Wayne-Union
Denny, Forrest L.	Indianapolis	Marion
Denny, Frank T.	Ladoga	Montgomery
Denny, J. W.	Indianapolis	Marion
Denny, Melvin H.	Rushville	Rush
Denton, Larkin D.	Greentown	Howard
Denzer, E. K.	Evansville	Vanderburgh
Denzer, Wm. Oliver	Evansville	Vanderburgh
Deputy, E. M.	Dugger	Sullivan
Deputy, Rolland	Seattle, Wash.	Marion
Derbyshire, John E.	Van Buren	Grant
Derhammer, G. L.	Brookston	Tippecanoe
Derian, M. H.	Gary	Lake
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Berne	Marion
DeTar, G. B.	Winslow	Pike
Detrick, H. W	Hammond	Lake
Dettloff, Frederick	Greencastle	Putnam
Deutsch, Wm.	Muncie	Delaware-Blackford
DeWees, Dwight L.	Indianapolis	Marion
Dewey, Fred N. (H)	Elkhart	Elkhart
Dewey, George W.	La Fayette	Tippecanoe
DeWitt, C. H.	Valparaiso	Porter
Diamond, Leo	Marlon	Grant
Diamondstein, Jos.	Calumet City, Ill.	Lake
Dian, A. J.	Gary	Lake
Dian, Julia G. Kuzmitz	Gary	Lake
Dick, Jack	Rensselaer	Jasper-Newton
Dickens, K. L.	Martinsville	Morgan
Dickinson, G. A.	Petersburg	Pike
Dickson, D. D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F.	Evansville	Vanderburgh
Dielman, F. C.	Fulton	Fulton
Dierolf, E. J.	Gary	Lake
Dieter, Wm. J.	Indlanapolis	Marion
Dietl, E. L.	South Bend	St. Joseph
Dillman, Carl E.	Corydon	Harrison
Dilts, Robert	Indianapolis	Marion
Dimond, E. Grey	Indianapolis	Marion
Dingle, Paul	Rlchmond	Wayne-Union
Dininger, W. S.	Winchester	Randolph
Dittmer, J. E.	Kouts	Porter
Dittmer, S. E.	Kouts	Porter
Dittmer, Thomas L.	Kouts	Porter
Ditton, I. W.	Fort Wayne	Allen
Dixon, Rex	Anderson	Madison
Dobbins, Thomas	Evansville	Vanderburgh
Dodd, Robert K.	Evansvllle	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Dollens, Claude	Oolltic	Lawrence
Dome, H. S.	Tell City	Perry
Donahue, C. M.	Carmel	Hamilton
Donahue, G. R.	La Fayette	Tippecanoe
Donato, Albert M.	Indianapolis	Marion
Donchess, J. C.	Gary	Lake
Donnelly, Robert W.	Sullivan	Sullivan
Donovan, S. J.	Michigan Clty	La Porte
Dorman, Jack	Indianapolis	Marion
Dorman, W. L.	Indianapolis	Marion
Dorrance, T. O.	Bluffton	Wells
Doty, Flavia M.	Gary	Lake
Doty, J. R.	Gary	Lake
Douglas, G. R.	Valparaiso	Porter
Douglas, William T.	Earl Park	Tippecanoe
Dowd, Joseph A.	Indianapolis	Marion
Dowell, E. H.	Rockville	Parke-Vermillion
Dragoo, Farrol	Middletown	Madison
Drake, John C.	Anderson	Madison
Draper, M. H.	Fort Wayne	Allen
Dreyer, Ralph W.	Knigbtstown	Henry
Drohan, E. P.	Cincinnati, O.	Dearborn-Ohio
Dubois, Charles C.	Warsaw	Kosciusko
Dubois, Franklin T.	Liberty	Wayne-Union
Dubois, R. B.	La Fayette	Tippecanoe
Dudding, J. E.	Hope	Bartholomew-Brown
Duemling, Arnold H.	Fort Wayne	Allen
Duemling, W. W.	Fort Wayne	Allen
Dugan, Thomas J.	Indianapolis	Marion
Dugan, Wm. M.	Indianapolis	Marion
Duggan, J. A.	South Bend	St. Joseph
Duke, B. E.	Decatur	Adams
Dukes, David A.	Tell City	Perry
Dukes, F. M.	Dugger	Sullivan
Dulin, Basil B.	Indianapolis	Marion
Dunbar, Colin V.	Indianapolis	Marion
Duncan, J. S.	Gary	Lake
Duncan, Wm. F. (H)	Aurora	Dearborn-Ohio
Dunham, W. F.	Kempton	Tipton
Dunlap, D. Logan	South Bend	St. Joseph
Dunlap, Harold	Indianapolis	Marlon
Dunn, F. W.	Muncie	Delaware-Blackford
Dunning, L. M.	Indianapolis	Marion
Dunstone, H. Carter	Fort Wayne	Allen
Dupes, L. E.	Hobart	Lake
Durkee, M. S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
Dutchess, C. T.	Galveston	Cass
Dutton, H. H.	Martinsville	Morgan
DuVall, W. N.	Mishawaka	St. Joseph
Dyar, E. W., Jr.	Indianapolis	Marlon
Dycus, W. A.	Evansville	Vanderburgh
Dyer, G. W.	Terre Haute	Vlgo
Dyer, Wallace K.	Indianapolis	Marion
Dykhuizen, T. A.	Frankfort	Clinton
Eades, Ralph C.	Valparaiso	Porter
Eastman, J. R., Jr.	Indianapolis	Marion
Eaton, E. R.	Indianapolis	Marlon
Eaton, L. D.	Franklin	Vanderburgh
Eaton, M. J.	La Fayette	Tippecanoe
Eberhart, L. L.	Angola	Steuben
Eberly, K. C.	Fort Wayne	Allen
Ebert, J. Wayne	Indianapolis	Marlon
Eberwein, J. H.	Indianapolis	Marion
Eby, Ida L.	Goshen	Elkhart
Echternacht, A. P.	Crawfordsville	Montgomery
Edlavitch, B. M.	Fort Wayne	Allen

Name	City	County
Edwards, Bernard	South Bend	St. Joseph
Edwards, W. F.	New Albany	Floyd
Egan, B. W.	Logansport	Cass
Egbert, H. L.	Indianapolis	Marion
Egbert, Roy	Indianapolis	Marion
Eggers, E. L.	Hammond	Lake
Eggers, H. W.	Hammond	Lake
Egnatz, Nicholas	Hammond	Lake
Ehrich, W. S.	Evansville	Vanderburgh
Ehrman, C. D.	Rockport	Spencer
Eichelberger, W. W.	Evansville	Vanderburgh
Eicher, Palmer	Oklahoma City, Okla.	Adams
Eifert, E. E.	Loogootee	Daviess-Martin
Eikenberry, H. W.	Indianapolis	Marion
Eisaman, C. L.	Columbia City	Marion
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, D. A.	Hammond	Lake
Eisenlohr, Eugene	Terre Haute	Vigo
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elledge, Ray	Hammond	Lake
Ellerbrook, George E.	Vevay	Switzerland
Ellett, John, Jr.	Coatesville	Hendricks
Elliott, John C.	Guilford	Dearborn-Ohio
Elliott, L. A.	Elkhart	Elkhart
Elliott, R. A.	Gary	Lake
Elliott, R. H.	Connersville	Fayette-Franklin
Ellis, Bert	Indianapolis	Marion
Ellis, L. H.	Lizton	Boone
Ellis, Seth	Anderson	Madison
Ellison, Alfred	South Bend	St. Joseph
Elsner, L. W.	Seymour	Jackson
Elsten, A. W.	Anderson	Madison
Elston, L. W.	Fort Wayne	Allen
Elston, Ralph W.	Fort Wayne	Allen
Emenhiser, Donald C.	New Haven	St. Joseph
Emenhiser, John L.	New Haven	Allen
Emery, Charles B.	Bedford	Lawrence
Emery, Charles H. (H)	Bedford	Lawrence
Emhardt, J. W. A.	Indianapolis	Marion
Emhardt, John T.	Indianapolis	Marion
Emme, R. W.	Harlan	Allen
Engel, E. L.	Evansville	Vanderburgh
Engeler, J. E.	La Fayette	Marion
Engle, J. M.	Portland	Jay
Engle, Russell B.	Winchester	Randolph
Englebert, W. F.	Tuscaloosa, Ala.	Allen
Engleman, H. K.	Georgetown	Floyd
English, C. H. (H)	Fort Wayne	Allen
English, H. E.	Rensselaer	Jasper-Newton
English, H. M.	Gary	Lake
English, J. P.	South Bend	St. Joseph
Ensminger, L. A.	Indianapolis	Marion
Entner, Charles L.	Connersville	Fayette-Franklin
Enzor, O. K.	Indianapolis	Marion
Episcopo, A. R.	Salem	Lawreuce
Epple, S. L.	Bristow	Perry
Erdel, Milton W.	Frankfort	Clinton
Erehart, A. D.	Anderson	Madison
Erehart, M. G.	Huntington	Huntington
Ericksen, Lester G.	South Bend	St. Joseph
Ericson, H. L.	Windfall	Tipton
Ernst, Clifford	Indianapolis	Marion
Ernst, H. C. W.	East Chicago	Lake
Erwin, H. G.	Lagrange	Lagrange
Eshleman, L. H.	Marion	Grant
Estel, G. A.	Madison	Jefferson
Estlick, R. E.	Fort Wayne	Allen
Ettl, Edward I.	Hot Springs, Ark.	Marion
Evans, Paul V.	Indianapolis	Marion
Evans, R. M.	Russiaville	Howard
Everly, Ralph	Indianapolis	Marion
Evers, Raymond	Madison, Wis.	St. Joseph
Eviston, J. B.	Huntington	Huntington
Ewing, Nathaniel D.	Camp Knox, Ky.	Knox
Fagaly, A. T. (H)	Lawrenceburg	Dearborn-Ohio
Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio
Fair, John R.	Wolf Lake	Noble
Faltin, Ladislaus	South Bend	St. Joseph
Farabee, Charles R.	North Judson	Starke
Fargher, F. M.	Michigan City	La Porte
Fargher, R. A.	La Porte	La Porte
Farnham, W. C.	South Bend	St. Joseph
Farnsworth, Sam A.	La Porte	La Porte
Farrell, J. T.	Indianapolis	Marion
Farver, M. A.	Middlebury	Elkhart
Faucett, Ralph E.	San Diego, Calif.	Wayne-Union
Faul, Henry J.	Evansville	Vanderburgh
Fausset, C. Basil	Indianapolis	Marion
Fanst, Walter H.	Little Rock, Ark.	Grant
Feerer, Donald J.	Michigan City	La Porte
Fender, A. H.	Worthington	Greene
Ferguson, A. N.	Fort Wayne	Allen
Ferguson, Wm. B.	Indianapolis	Marion
Ferrara, Donald W.	Peru	Miami
Ferrara, S. J.	Peru	Miami
Ferree, John W.	New York, N. Y.	Marion
Ferrell, Jesse E.	Fortville	Hancock
Ferrell, Mars B.	Fortville	Hancock
Ferry, John L.	Whiting	Lake
Ferry, P. W.	Kokomo	Howard
Fessler, G. S.	Rising Sun	Dearborn-Ohio
Fichman, A. M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Filipek, W. J.	South Bend	St. Joseph
Fipp, August L.	Rome City	Noble
Firestein, Ben	South Bend	St. Joseph
Firestein, Ray	South Bend	St. Joseph
Fisch, Charles	Indianapolis	Marion
Fischer, C. N.	La Porte	La Porte
Fish, C. M.	South Bend	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Albert	North Judson	La Porte
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, K. B.	Gleudale, Calif.	St. Joseph
Fisher, Lawrence F.	South Beud	St. Joseph
Fisher, Pierre J.	Marion	Grant
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisk, Frank B.	Indianapolis	Marion
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, H. W.	Elwood	Madison
Fitzpatrick, James S.	Indianapolis	Marion
Fitzsimmons, E. L.	Evansville	Vanderburgh
Flack, Russell A.	La Fayette	Tippecanoe
Flanagan, E. P.	Walton	Cass
Flanigan, M. B.	Indianapolis	Tippecanoe
Flannigan, H.F.	Lagrange	Lagrange
Fleetwood, R. A.	Nappanee	Elkhart
Fleischer, J. C.	East Chicago	Lake
Fleming, C. F.	Elkhart	Elkhart
Fleming, Justus M.	Elkhart	Elkhart
Fletcher, Charles F.	Sunmau	Dearborn-Ohio
Flick, John J.	Indianapolis	Marion
Flinn-Jordou-Minnetta	Wabash	Wabash
Flora, Joseph O.	Indianapolis	Marion
Folck, J. K.	Princeton	Gibson
Folkening, N. C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Folz, C. J.	Evansville	Vanderburgh
Forbes, Violet Crabbe	Wolcott	Tippecanoe
Foreman, Harry L.	Indianapolis	Marion
Foreman, W. A.	Brookville	Fayette-Franklin
Forry, Frank	Indianapolis	Marion
Forster, N. K.	Hammond	Lake
Forsyth, D. H.	Terre Haute	Vigo
Fosbrink, E. L.	Syracuse	Elkhart
Fosler, D. W.	Indianapolis	Marion
Fouts, Joseph R.	English	Crawford
Fouts, Paul J.	Indianapolis	Marion
Fox, C. Philip	Washington	Daviess-Martin
Fox, M. S.	Vincennes	Knox
Fox, R. H.	Bicknell	Knox
Foy, H. W.	Fort Wayne	Allen
Frank, J. R.	Valparaiso	Porter
Frank, L. L.	South Bend	St. Joseph
Franklin, Ernest J.	Indianapolis	Marion
Franklin, Philip L.	Gary	Lake
Frankowski, Clemen-tine	Whiting	Lake
Frantz, Mount E.	Danville	Hendricks
Frasch, M. G.	La Fayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Freed, James C.	Attica	Fountain-Warren
Freed, John E., Sr.	Terre Haute	Vigo
Freed, John E., Jr.	Terre Haute	Vigo
Freeman, F. M.	Goshen	Elkhart
French, Virgil	Riley	Vigo
French, Wm. G.	Evansville	Vanderburgh
Friedman, Isadore E.	Munster	Lake
Friedrich, L. M.	Hobart	Lake
Frith, Gladys D.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fritsch, L. E.	Evansville	Vanderburgh
Fromhold, Willis A.	Indianapolis	Marion
Fry, Robert D.	Indianapolis	Marion
Frybarger, S. S.	Converse	Miami
Fullerton, R. L.	Indianapolis	Marion
Funk, John W.	Muncie	Delaware-Blackford
Funkhouser, A. G.	Indianapolis	Marion
Funkhouser, Elmer	Indianapolis	Marion
Fuqua, Harold B.	Terre Haute	Vigo
Furgason, Paul C.	Indianapolis	Marion
Furniss, S. A.	Indianapolis	Marion
Fuson, W. J.	Greencastle	Putnam
Fyfe, M. B.	Valparaiso	Porter
Gabe, Harry E. (H)	Indianapolis	Marion
Gabe, Wm. E.	Indianapolis	Marion
Gable, H. B.	Monticello	White
Gaddy, Euclid T.	Indianapolis	Marion
Galante, Vincent J.	Chicago, Ill.	Lake
Galbreath, R. S.	Huntington	Huntington
Galbreth, J. P.	Burnettsville	White
Gallup, Palmer R.	Indianapolis	Marion
Gambill, Wm. D.	Indianapolis	Marion
Gannon, G. W.	Gary	Lake
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, H. W.	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, E. C.	Dunkirk	Jay
Garber, J. Neill	Indianapolis	Marion
Garber, Paul A.	South Whitley	Whitley
Garceau, George J.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, H. G.	Hammond	Lake
Gardner, M. D.	Michigan City	La Porte
Garfield, M. D.	Indianapolis	Marion
Garland, Edgar A.	Evansville	Vanderburgh
Garling, L. C.	Muncie	Delaware-Blackford
Garner, William	Indianapolis	Marion
Garner, W. Stanley	Indianapolis	Marion
Garner, Wm. H.	New Albany	Floyd
Garrett, John D.	Indianapolis	Marion
Garrison, Leon J.	Gas City	Grant
Garton, H. W.	Fort Wayne	Allen
Gastineau, F. M.	Indianapolis	Marion
Gatch, W. D	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Gehres, R. W.	Shelbyville	Shelby
Geick, Raymond	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon	Bloomington	Owen-Monroe

Name	City	County
Geisel, E. E.	Gary	Lake
Geisinger, L. N.	Auburn	De Kalb
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Gerrish, D. A.	Terre Haute	Vigo
Gerrish, W. D.	Clinton	Parke-Vermillion
Gery, Richard E.	La Fayette	Tippecanoe
Gessler, W. F.	Fort Wayne	Allen
Gevirtz, M. B.	Hammond	Lake
Gibbs, Charles	Greenfield	Hancock
Gibbs, E. R.	Wilkinson	Hancock
Gibbs, Joseph W.	Danville	Hendricks
Gibson, J. J. (H)	Alexandria	Madison
Gick, Herman	Indianapolis	Marion
Gifford, F. E.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo
Gilkison, J. S.	Sboals	Daviess-Martin
Gill, B. P.	Mitchell	Vanderburgh
Gill, D. D.	Greenfield	Hancock
Gillespie, C. E.	Seymour	Jackson
Gillespie, C. F.	Indianapolis	Marion
Gillespie, Chauncey	Soutb Bend	St. Josepb
Gillespie, G. R.	Brownstown	Jackson
Gillespie, J. E.	Indianapolis	Marion
Gillespie, J. F. (H)	Greencastle	Putnam
Gilliatt, J. P.	Salem	Washington
Gilliom, Luther A.	Washington, D. C.	Marion
Gillum, John R.	Terre Haute	Vigo
Gilman, M. M.	South Bend	St. Josepb
Gilmore, L. L.	Vincennes	Knox
Gilmore, R. A.	Michigan City	La Porte
Gingerich, C. M.	Liberty Center	Wells
Ginsberg, Stewart	Marion	Grant
Giordano, A. S.	South Bend	St. Joseph
Giorgi, Antonio (H)	Gary	Lake
Gitlin, Max M.	Bluffton	Wells
Gitlin, Wm. A.	Bluffton	Wells
Glackman, J. C., Sr.	Rockport	Spencer
Gladstone, N. H.	Fort Wayne	Allen
Glaser, E. M.	Brookville	Fayette-Franklin
Glass, R. L.	Indianapolis	Marion
Glendening, J. L.	Indianapolis	Marion
Glenn, Fred C.	Tell City	Perry
Glenn, L. F.	Ramsey	Harrison
Glick, O. E.	Kentland	Jasper-Newton
Glock, H. E.	Fort Wayne	Allen
Glock, M. E.	Fort Wayne	Allen
Glock, Wayne R.	Fort Wayne	Allen
Gobbel, N. E.	English	Crawford
Godersky, Lois	Indianapolis	Carroll
Godwin, J. David	New Palestine	Marion
Goethals, Charles J.	Misbawaka	St. Josepb
Goldberg, Harold B.	Gary	Lake
Goldman, Samuel	Indianapolis	Marion
Goldstone, Adolpb	Gary	Lake
Goldstone, Joseph	Gary	Lake
Good, R. P.	Kokomo	Howard
Goodman, Eli	Charlestown	Clark
Goodman, H. T.	Terre Haute	Vigo
Goodrich, Albert	Indianapolis	Marion
Goodrum, Wm. R.	Elkbart	Elkbart
Goodwin, C. B. (H)	Kendallville	Noble
Goodwin, Caroline M.	Indianapolis	Marion
Goraczewski, Thaddeus	Soutb Bend	St. Josepb
Gordin, Stanley	Connersville	Fayette-Franklin
Gordin, Stanton E. (H)	Connersville	Fayette-Franklin
Gordon, J. L.	Wheeler	Porter
Gordon, J. M.	South Bend	St. Joseph
Gosman, James H.	Indianapolis	Marion
Goss, H. W.	Indianapolis	Marion
Gould, L. K.	Fort Wayne	Allen
Govorchin, Alexander	East Chicago	Lake
Graessle, Harold P.	Seymour	Jackson
Graf, John E.	Fort Wayne	Marion
Graf, Jerome A.	Bloomfield	Greene
Graham, A. B. (H)	Ligonier, Pa.	Marion
Graham, Cova R.	Bourbon	Marshall
Graham, Thomas	La Fayette	Tippecanoe
Gramling, J. J.	Indianapolis	Marion
Grant, Benjamin F.	Gary	Lake
Graves, J. W.	Indianapolis	Marion
Graves, Orville M.	Princeton	Gibson
Gray, D. E.	Crown Point	Lake
Gray, Leon	Martinsville	Morgan
Gray, Paul M.	Huntington	Huntington
Grayston, F. W.	Huntington	Huntington
Grayston, Wallace S.	Huntington	Huntington
Green, F. H., Jr.	Rushville	Rush
Green, George F.	South Bend	St. Joseph
Green, John H.	North Vernon	Jennings
Green, Lowell M.	Rusbville	Rush
Green, Myron H.	Boston, Mass.	Marion
Green, S. I.	St. Bernice	Parke-Vermillion
Green, Wm. L.	Pekin	Washington
Greene, F. G.	Bloomingdale	Parke-Vermillion
Greer, O. W.	Denver, Colo.	Marion
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregoline, A. F.	Gary	Lake
Greist, H. W. (H)	Monticello	White
Greist, John	Indianapolis	Marion
Griest, O. E.	La Fayette	Tippecanoe
Griffin, J. P.	Chesterton	Porter
Griffis, V. C.	Richmond	Wayne-Union
Griffith, J. B.	Crawfordsville	Montgomery
Griffith, James W.	Sheridan	Hamilton
Griffith, R. E.	Indianapolis	Marion
Grillo, Donald	South Bend	St. Joseph
Grimes, J. H.	Martinsville	Hendricks
Grisell, Ted L.	Indianapolis	Marion
Griswold, W. R.	Indianapolis	Marion
Groman, H. C.	Hammond	Lake
Gros, Hubert	Delphi	Carroll
Gross, M. E.	Ladoga	Montgomery
Grosskrentz, Doris	Evansville	Vanderburgh
Grossman, W. L.	North Vernon	Jennings
Grossnickle, Geo. W.	Elkhart	Elkhart
Grosso, W. G.	East Chicago	Lake
Grove, E. G.	Shelbyville	Shelby
Grove, Robert H.	Rossville	Clinton
Grzesk, Leo L.	Granite City, Ill.	St. Joseph
Gudenkauf, Elton B.	Jeffersonville	Clark
Gustafson, G. W.	Indianapolis	Marion
Gutellus, C. B.	Indianapolis	Marion
Guthrie, F. C.	Anderson	Madison
Gutierrez, F. A.	Gary	Lake
Gutstein, Richard R.	Kendallville	Noble
Gwaltney, L. F.	Roachdale	Putnam
Gwartney, Richard H.	Muncie	Delaware-Blackford
Gwin, M. D.	Miami Beach, Fla.	Jasper-Newton
Habegger, Myron L.	Berne	Adams
Habermel, John F.	New Albany	Floyd
Habich, Carl	Indianapolis	Marion
Hack, E. C.	Hammond	Lake
Hadden, Claude E.	Indianapolis	Marion
Hade, Frederick L.	Bridgeport	Marion
Hadley, A. W.	Indianapolis	Tippecanoe
Hadley, David	Indianapolis	Marion
Hadley, Harvey	Richmond	Wayne-Union
Hadley, Murray N.	Indianapolis	Marion
Haffner, H. G.	Fort Wayne	Allen
Haggard, E. B.	Indianapolis	Marion
Hagie, F. E.	Richmond	Wayne-Union
Hahn, E. V.	Indianapolis	Marion
Haley, Paul E.	South Bend	St. Josepb
Hall, E. H.	Dunkirk	Delaware-Blackford
Hall, Frank M.	Indianapolis	Tippecanoe
Hall, Jack R.	Indianapolis	Marion
Hall, O. A.	Muncie	Delaware-Blackford
Hall, T. C.	Chesterton	Porter
Hallam, F. T.	Indianapolis	Marion
Halleck, H. J.	Winamac	Pulaski
Haller, Thomas C.	Williamsport	Fountain-Warren
Hamer, H. G.	Indianapolis	Marion
Hamilton, Alexander	Frankfort	Clinton
Hamilton, Antha A.	Shelburn	Sullivan
Hamilton, E. E.	Dayton	Tippecanoe
Hamilton, Guy W.	Madison	Jefferson
Hamilton, H. B.	Indianapolis	Vigo
Hamilton, J. R.	Mitchell	Lawrence
Hamilton, M. Luther	Newberry	Greene
Hamilton, O. G.	Bluffton	Wells
Hamilton, R. C.	East Chicago	Lake
Hammersley, Geo. K.	Frankfort	Clinton
Hammond, Keith	Paoli	Orange
Hammond, Stanley M.	Portland	Jay
Hampshire, Don R.	Indianapolis	Marion
Hancock, John G.	Indianapolis	Marion
Hane, R. L.	Fort Wayne	Allen
Hanna, T. A.	Indianapolis	Marion
Hannah, Jack W.	Wakarusa	Elkhart
Hansell, R. M.	Indianapolis	Marion
Hansen, A. H.	Hammond	Lake
Hanson, Martin F.	Elwood	Madison
Harcourt, A. K.	Indianapolis	Marion
Harden, Murray E.	Indianapolis	Fountain-Warren
Hardesty, K. C.	Fort Wayne	Allen
Hardin, W. E.	Ossian	Wells
Harding, M. Richard	Fayetteville, N. C.	Marion
Harding, Myron S.	Indianapolis	Marion
Hardy, Charles F.	Kendallville	Noble
Hardy, John J.	North Liberty	St. Joseph
Hare, E. H.	Indianapolis	Marion
Hare, John H.	Evansville	Vanderburgh
Hare, Laura	Indianapolis	Marion
Hargis, W. T. (H)	Tell City	Perry
Harkcom, H. E.	St. Paul	Decatur
Harkness, R. G.	Terre Haute	Vigo
Harmon, C. J.	Richmond	Wayne-Union
Harmon, Gladys H.	Richmond	Wayne-Union
Harmon, Vachelle E.	South Bend	St. Joseph
Harmon, Wayne	Lynn	Randolpb
Harold, A. H.	Indianapolis	Marion
Harold, N. E.	Indianapolis	Marion
Harris, B. W.	Gary	Lake
Harris, Carl B.	Indianapolis	Marion
Harris, L. E.	La Fayette	Tippecanoe
Harris, Paul N.	Indianapolis	Marion
Harris, R. F.	Noblesville	Hamilton
Harris, W. L.	Evansville	Vanderburgh
Harrison, B. L.	New Castle	Henry
Harrison, Wm. H. (H)	Kokomo	Howard
Harshman, L. P.	Fort Wayne	Allen
Harshman, Martin L.	Colfax	Clinton
Harstad, C.	Rockville	Parke-Vermillion
Hart, L. Paul	Evansville	Vanderbnrgb
Hart, Robert B.	Columbus	Bartholomew-Brown
Hart, Wm. D.	Anderson	Madison
Hartley, C. A., Jr.,	Evansville	Vanderburgh
Hartley, C. A.	Evansville	Vanderburgh
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Bennett B.	Knightstown	Henry
Harvey, B. J.	Inglewood, Calif.	Tippecanoe
Harvey, Harry C.	Fort Wayne	Allen
Harvey, R. J.	Zionsville	Boone
Harvey, Verne K.	Washington, D. C.	Marion

Name	City	County
Hasewinkle, A. M.	Fort Wayne	Allen
Hash, John S.	Noblesville	Hamilton
Haskell, Cosa D.	Indianapolis	Marion
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Haslinger, C. J.	Indianapolis	Marion
Hatfield, B. F.	Indianapolis	Marion
Hatfield, N. W.	Indianapolis	Marion
Hathaway, Clayton B.	Butler	De Kalb
Hattendorf, A. P.	Fort Wayne	Allen
Hauss, A. P.	New Albany	Floyd
Havens, Edward D.	Cicero	Hamilton
Havens, Oscar	Cicero	Hamilton
Havens, R. E.	Oak Park, Ill.	Hamilton
Havice, Jay F.	Asheville, N.C.	Allen
Hawes, J. K.	Columbus	Bartholomew-Brown
Hawes, M. E.	Columbus	Bartholomew-Brown
Hawk, James H.	Indianapolis	Marion
Hayes, J. J.	Holland, Mich.	Allen
Hayes, T. R.	Muncie	Delaware-Blackford
Haymond, Joseph L.	South Bend	St. Joseph
Hays, E. L.	Indianapolis	Marion
Hays, George R.	Richmond	Wayne-Union
Hazel, James T. (H)	Freedom	Owen-Monroe
Headley, L. M.	Lebanon	Boone
Heald, Walter	West Lebanon	Fountain-Warren
Healy, Wm. F.	Evansville	Vanderburgh
Heard, Albert	Evansville	Vanderburgh
Heberer, J. M.	Evansville	Vanderburgh
Heck, M. C.	Jasper	Dubois
Hedde, E. L.	Logansport	Cass
Hedgcock, R. A.	Frankfort	Clinton
Hefti, Karl	Evansville	Vanderburgh
Hegarty, W. M., Jr.	Newport	Parke-Vermillion
Heilman, W. C.	New Castle	Henry
Heinrich, H. H.	Indianapolis	Marion
Heinz, Dorothy C. V.	Indianapolis	Marion
Held, George A.	Jasper	Dubois
Heller, N. L.	Dunkirk	Jay
Heller, Oscar	Greenfield	Hancock
Helmen, H. W.	South Bend	St. Joseph
Helper, Morton	Evansville	Vanderburgh
Henderson, Arvin	Ridgeville	Randolph
Henderson, R. A.	Muncie	Delaware-Blackford
Hendricks, John D.	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Henley, Glenn	Fairmount	Grant
Hennessee, Philip C.	Indianapolis	Marion
Henning, Carl	Hanover	Jefferson
Henry, Russell S.	Indianapolis	Marion
Hensler, B. M.	Anderson	Madison
Hepburn, C. K.	Indianapolis	Marion
Hepner, H. S.	Bloomington	Owen-Monroe
Herbst, R. R.	Hammond	Lake
Herd, Cloyn R.	Peru	Miami
Herendeen, E. V.	Rochester	Fulton
Heritler, Jules	Columbia City	Whitley
Herr, John W.	Mount Vernon	Posey
Herrick, C. L.	Akron	Fulton
Herring, G. N.	Pierceton	Kosclusko
Herrold, G. W.	La Fayette	Tippecanoe
Hershey, E. A.	Churubusco	Whitley
Hervey, Samuel W. (H)	Fortville	Hancock
Herzer, C. C.	Evansville	Vanderburgh
Hetherington, A. M.	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion
Heubi, John E.	Indianapolis	Marion
Hewins, Warren W.	Evansville	Vanderburgh
Hewitt, John H.	Indianapolis	Fountain-Warren
Hewitt, M. I.	South Bend	St. Joseph
Hewlett, Thomas H.	New Albany	Floyd
Hiatt, R. L.	Chicago, Ill.	Wayne-Union
Hibner, Nolan A.	Monticello	Marion
Hickman, W. R.	Logansport	Cass
Hickman, Walter	Indianapolis	Marion
Hicks, H. S.	Hammond	Lake
Hlestand, H. B.	Philadelphia, Pa.	Jay
Hiestand, H. J.	Pennville	Jay
Higbee, Paul	Sullivan	Sullivan
Higgins, O. C.	Lebanon	Boone
Hilbert, John W.	South Bend	St. Joseph
Hildebrand, W. O.	Topeka	Lagrange
Hill, H. D.	Richmond	Wayne-Union
Hill, H. E.	Muncie	Delaware-Blackford
Hill, Kenneth G.	Middletown	Tippecanoe
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert	Muncie	Delaware-Blackford
Hill, T. N.	Scottsburg	Scott
Hilldrup, Don G.	Fort Sill, Okla.	Marion
Hillery, J. L.	Warsaw	Kosciusko
Hillis, L. J.	Logansport	Cass
Hillman, Marion W.	South Bend	St. Joseph
Hillman, W. H.	South Bend	St. Joseph
Himebaugh, Gilbert	Veedersburg	Marion
Himebaugh, J. R. S.	Morocco	Marion
Himler, James M.	Indianapolis	Marion
Hinchman, C. P.	Geneva	Adams
Hinchman, Jean F.	Parker	Delaware-Blackford
Hine, Ulls B.	Indianapolis	Marion
Hines, A. V.	Auburn	De Kalb
Hines, D. M.	Auburn	De Kalb
Hines, Don C.	Indianapolis	Marion
Hinkson, George D.	Gary	Lake
Hippensteel, R. R.	Indianapolis	Marion
Hippensteele, R. O.	Fremont	Steuben
Hisrich, L. W.	Batesville	Ripley
Hochhalter, Marian	Logansport	Cass
Hodges, Fletcher	Indianapolis	Marion
Hodges, Wm. A.	Oaktown	Knox
Hodurski, Zigfield	Gary	Lake
Hoeger, H. R.	Brookville	Fayette-Franklin
Hoetzer, Eldore M.	New Haven	Allen
Hofferkamp, A. G.	Louisville, Ky.	Floyd
Hoffman, A. F.	Fort Wayne	Allen
Hoffman, Curtis R.	Richmond	Wayne-Union
Hoffman, Doris	Vincennes	Knox
Hoffman, R. V.	South Bend	St. Joseph
Hoffman, S. P., Sr.	Fort Wayne	Allen
Hoffman, S. P., Jr.	Fort Wayne	Allen
Hofmann, Andrew	Hammond	Lake
Hofmann, J. Wm.	Indianapolis	Marion
Holdeman, Lillian	South Bend	St. Joseph
Holdeman, R. W.	South Bend	St. Joseph
Holladay, L. J.	La Fayette	Tippecanoe
Holland, Chas. E.	Bloomington	Owen-Monroe
Holland, D. J.	Bloomington	Owen-Monroe
Holland, E. E.	Richmond	Wayne-Union
Holland, Philip	Bloomington	Owen-Monroe
Hollday, L. D.	Fairmount	Grant
Hollingsworth, A. A.	Indianapolis	Marion
Hollingsworth, Marshall P. (H)	Princeton	Gibson
Hollingsworth, Maurice	Los Angeles, Calif.	Marion
Holloway, W. A.	Logansport	Cass
Holman, J. E., Sr.	Indianapolis	Marion
Holman, J. E. Jr.	Indianapolis	Marion
Holmes, Claude D.	Frankfort	Clinton
Holmes, G. W.	Chicago, Ill.	Lake
Holmes, W. W.	Logansport	Cass
Holsinger, R. E.	Fort Wayne	Allen
Holtzendorf, C. E. (H)	Plymouth	Marshall
Hood, Ainslee A.	Indianapolis	Marion
Hooke, Sam W.	Noblesville	Hamilton
Hoopes, Jane	Evansville	Vanderburgh
Hoover, D. A.	Terre Haute	Vigo
Hoover, J. Guy	Boonville	Warrick
Hoover, J. J.	Terre Haute	Vigo
Hoover, Peter B.	Boonville	Warrick
Hopkins, Lester H.	Versailles	Ripley
Hoppenrath, W. M.	Elwood	Madison
Hoppenrath, Wm. H.	Elwood	Madison
Hornaday, W. A.	Hammond	Lake
Horsman, Russell	Indianapolis	Howard
Horswell, R. G.	Bristol	Elkhart
Horton, George R.	Peru	Marion
Hostetler, Carl M.	Goshen	Elkhart
Houser, A. D.	Mohonk Lake, N. Y.	St. Joseph
Houser, Wayne W.	Monon	Tippecanoe
How, John T.	Lakeville	St. Joseph
How, Louis E.	Lakeville	St. Joseph
Howard, C. W.	Crawfordsville	Montgomery
Howard, W. H.	Hammond	Lake
Howell, R. D.	Indianapolis	Marion
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Carl D.	Danville	Hendricks
Huckleberry, Irvin	Salem	Washington
Hudson, Foster J.	Indianapolis	Marion
Huff, A. D.	Marion	Grant
Huffman, A. D.	South Bend	St. Joseph
Huffman, V. P.	South Whitley	Whitley
Hufnagel, C. A.	Richmond	Wayne-Union
Huggins, Vietor S.	Evansville	Vanderburgh
Hughes, J. E.	Indianapolis	Marion
Hughes, L. M.	Paragon	Morgan
Hughes, W. F.	Indianapolis	Marion
Hull, A. W.	Elkhart	Elkhart
Hull, King L.	Bloomfield	Greene
Hulsman, L. F.	Richland, Wash.	Shelby
Hummel, R. M.	Marion	Grant
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John W.	Darlington	Montgomery
Hunn, M. F.	Elkhart	Elkhart
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunt, W. B. (H)	Terre Haute	Vigo
Hunter, F. P.	La Fayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hupe, Charles (H)	La Fayette	Tippecanoe
Hurley, Anson	Muncie	Delaware-Blackford
Hurley, John R.	Daleville	Delaware-Blackford
Hursey, Virgil G.	Milford	Kosciusko
Hurst, E. M.	Cloverdale	Putnam
Hurt, L. B.	Indianapolis	Marion
Hurt, Paul T.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutcheson, W. R.	Greencastle	Putnam
Hutchings, B. M.	Terre Haute	Vigo
Hutchinson, B. M.	Mishawaka	St. Joseph
Hutto, W. H.	Kokomo	Howard
Hyde, Carroll	South Bend	St. Joseph
Hyman, Bernard	Chicago, Ill.	Marion
Hynes, Roy	Indianapolis	Marion
Iddings, J. W.	Crown Point	Lake
Ikins, R. G.	La Fayette	Tippecanoe
Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	LaPorte
Inlow, C. Fred	Shelbyville	Shelby
Inlow, Herbert	Shelbyville	Shelby
Inlow, W. D.	Shelbyville	Shelby
Irey, P. R.	Plymouth	Marshall
Irish, Wilbur J.	East Chicago	Lake
Irwin, Glenn W., Jr.	Roachdale	Marion
Irwin, Seth	Summitville	Madison
Ish, E. A.	Waterloo	De Kalb
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski

Name	City	County
Jackman, Abraham I.	Address Unknown	Lake
Jackson, F. E.	Indianapolis	Marion
Jackson, J. K.	Aurora	Dearborn-Oblo
Jackson, J. L.	Indianapolis	Marion
Jackson, J. M.	Aurora	Dearborn-Ohio
Jackson, J. W.	Indianapolis	Marion
Jacobs, H. A.	Indianapolis	Marion
Jacobs, L. G.	Santa Fe, N. M.	Marion
Jaeger, A. S.	Indianapolis	Marion
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jaquith, O. S.	Indianapolis	Marion
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jeffries, K. I.	Indianapolis	Marion
Jenkins, J. M. (H)	Cortland	Jackson
Jenkinson, W. E.	Albany, N. Y.	Posey
Jennings, Frank	Indianapolis	Marion
Jerome, J. N. (H)	Evansville	Vanderburgh
Jewell, Earl B.	Logansport	Cass
Jewett, Joe H.	Indianapolis	Marion
Jewett, Robert E.	Indianapolis	Marion
Jinks, C. H.	Indianapolis	Marlon
Jinnings, Loren E.	Garrett	De Kalb
Jobes, James E.	Indianapolis	Marion
Jobes, N. E.	Indianapolis	Marion
Joest, Charles O.	Mishawaka	St. Joseph
Johns, D. R.	East Cbicago	Lake
Johns, N. C.	Argos	Marshall
Johnson, C. E.	Rensselaer	Jasper-Newton
Johnson, E. N.	Sandborn	Knox
Johnson, Earl E.	Covington	Fountain-Warren
Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C.	Evansville	Vanderburgh
Johnson, James B.	Greencastle	Putnam
Johnson, J. J.	Milltown	Crawford
Johnson, Lowell R.	Indianapolis	Marion
Johnson, M. H. C.	Vincennes	Knox
Johnson, Paul S.	Richmond	Wayne-Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke-Vermillion
Johnson, Wm. F.	Indianapolis	Marion
Johnston, D. D.	Sioux Falls, S. D.	Allen
Johnston, R. G.	Huntington	Huntington
Jolly, Lewis E.	Madison	Knox
Jolly, W. P.	Richland	Spencer
Jones, Albert T.	Pendleton	Madison
Jones, Charles A.	Franklin	Johnson
Jones, Clifford M.	Whitlng	Lake
Jones, D. D.	Berne	Adams
Jones, David E.	Indianapolis	Marion
Jones, E. F.	Marion	Grant
Jones, E. S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George	Wanamaker	Marion
Jones, H. E.	Anderson	Madison
Jones, R. B.	La Porte	La Porte
Jones, Rilus E.	Los Angeles, Calif.	Hendricks
Jones, W. W.	Frankfort	Clinton
Jordan, Leo E.	Lynn	Randolph
Joseph, Herbert L.	Indianapolis	Marion
Josepb, Rex M.	Indianapolis	Marion
Josif, Lazar	East Chicago	Lake
Kabel, Robert N.	Indianapolis	Marion
Kahan, H. L.	Gary	Lake
Kahler, M. V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kalb, Everett L.	Indianapolis	Marion
Kaler, James	Plymouth	Marshall
Kamm, Bernard A.	South Bend	St. Joseph
Kamman, G. H.	Seymour	Jackson
Kamman, H. H.	Columbus	Bartbolomew-Brown
Kammen, Leo	Indianapolis	Marion
Kammer, Adolph G.	Oak Ridge, Tenn.	Lake
Kantzer, Floyd B.	Garrett	De Kalb
Kaplan, Benjamin B.	East Chicago	Lake
Karpel, Bernard	Mooresville	Morgan
Karsell, W. A.	Bloomington	Owen-Monroe
Katterjohn, James C.	Philadelphia, Pa.	Marion
Kauffman, H. M.	Evansville	Vanderburgh
Kauffman, Sidney A.	Indianapolis	Marion
Kay, Oran	Spencer	Owen-Monroe
Keefe, Thomas L.	Logansport	Cass
Keeling, F. E.	Portland	Jay
Keeling, J. E. (H)	Waldron	Shelby
Keenan, R. L.	Indianapolis	Marion
Keever, C. H.	Indianapolis	Marion
Keiser, V. D.	Indianapolis	Marion
Keith, F. E.	St. Bernice	Parke-Vermillion
Keller, F. G. (H)	Alexandria	Madison
Kelly, Don E.	Indianapolis	Marion
Kelly, F. H.	Argos	Marsball
Kelly, J. F.	Indianapolis	Marion
Kelly, J. N.	La Porte	La Porte
Kelly, W. C.	Anderson	Madison
Kelly, W. R.	Goshen	Elkhart
Kelly, Walter F.	Indianapolis	Marion
Kelly, William M.	Indianapolis	Marion
Kelsey, A. J.	Monterey	Pulaski
Kelsey, L. E.	Kewanna	Fulton
Kelsey, Robert M.	La Porte	La Porte
Kemp, John T.	Michigan City	La Porte
Kemp, W. A.	Connersville	Fayette-Franklin
Kemper, A. T.	Muncie	Delaware-Blackford
Kempf, G. F.	Indianapolis	Marion
Kendall, F. M.	Nappanee	Elkhart
Kendrick, Frank J.	Gary	Lake
Kendrick, W. M.	Indianapolis	Marion
Kennedy, Eva	Camden	Carroll
Kennedy, H. F.	Indianapolis	Marion
Kennedy, R. O.	Rushville	Rush
Kennedy, Samuel (H)	Shelbyville	Shelby
Kennedy, W. U.	New Castle	Henry
Kenney, Francis D.	Hammond	Lake
Kennington, D. J.	Michigan City	La Porte
Kent, J. A.	Mulberry	Clinton
Kenyon, C. E.	Cambridge City	Wayne-Union
Kepler, R. W.	La Porte	La Porte
Kercheval, J. M.	Clinton	Parke-Vermillion
Kern, C. B.	Muncie	Delaware-Blackford
Kern, C. G.	Lebanon	Boone
Kerr, A R.	Attica	Fountain-Warren
Kerr, Harry R.	Indianapolis	Marion
Kerrigan, R. L.	Michigan City	LaPorte
Ketcham, Jane M.	Indianapolis	Marion
Ketcham, John S.	Rossville	Clinton
Kidd, James G.	Roann	Wabash
Kidder, J. J.	Salamonia	Jay
Kidder, Orva T.	Fort Wayne	Allen
Kilgore, Byron, Jr.	Indianapolis	Hendricks
Kilgore, F. T.	Yorktown	Delaware-Blackford
Killough, Aimee R.	Michigan City	La Porte
Kilmer, John H.	Fort Wayne	Allen
Kim, Young D.	Beecb Grove	Marion
Kimball, Glen D.	Marion	Grant
Kimbrough, Robert F.	Indianapolis	Marion
Kime, Charles E.	Indianapolis	Marion
Kime, E. N.	Bloomington	Marion
Kime, J. T. (H)	Petersburg	Pike
Kindell, H. D.	New Richmond	Montgomery
King, B. A.	Anderson	Madison
King, Everett A.	Evansville	Vanderburgh
King, Jack	Vevay	Switzerland
King, James R.	Silver Lake	Kosciusko
King, Joseph W.	Anderson	Madison
King, M. O.	Rocbester	Fulton
King, P. C.	Swayzee	Grant
King, Wm. E.	Indianapolis	Marion
Kingsbury, J. K.	Indianapolis	Marion
Kinnaman, H. A.	Crawfordsville	Montgomery
Kinneman, R. E.	Greenfield	Hancock
Kinsey, Joseph H.	Richmond	Wayne-Union
Kirch, L. N.	Indianapolis	Marion
Kirkpatrick, A. M. (H)	Columbus	Bartholomew-Brown
Kirshman, F. E.	Muncie	Delaware-Blackford
Kirtley, J. M.	Crawfordsville	Montgomery
Kiser, E. F.	Indianapolis	Marion
Kissinger, K. L.	Angola	Steuben
Kistner, Arthur W.	Elkhart	Elkhart
Kistner, John W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klahr, Elsworth	South Bend	St. Joseph
Klain, B. V.	Indianapolis	Marion
Klaus, Julius M.	Greenwood	Marion
Kleln, H. P.	Fort Branch	Gibson
Kleindorfer, R. L.	Evansville	Vanderburgh
Kleinman, F. J.	Hebron	Porter
Klepinger, H. E.	La Fayette	Tippecanoe
Klingler, Maurice O.	Plymouth	Marshall
Klotz, Joseph G.	Indianapolis	Marion
Knapp, A. B. (H)	Vincennes	Knox
Knapp, Arthur L.	South Bend	St. Joseph
Knepple, L. R.	Kokomo	Howard
Knode, Kenneth T.	South Bend	St. Joseph
Knoefel, Peter	Louisville, Ky.	Vigo
Knoy, Norris J.	Gary	Lake
Kobrak, H. F.	Gary	Lake
Kobrin, M. W.	Gary	Lake
Koehler, Elmer G.	Elkhart	Elkhart
Kohlstaedt, George	Indianapolis	Marion
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, K. G.	Indianapolis	Marion
Kohne, G. J.	Decatur	Adams
Kolanko, Leon A.	Hammond	Lake
Kolettis, George J.	Gary	Lake
Komoroske, J. E.	East Chicago	Lake
Koons, Karl M.	Indianapolis	Marion
Koontz, William A.	Tipton	Marion
Kopcha, Joseph E.	Wbiting	Lake
Kopp, Herschel S.	Indianapolis	Marion
Kopp, O. A.	Anderson	Madison
Korn, Jerome M.	Gary	Marion
Kornafel, L. H.	Indianapolis	Marion
Kraft, Bennett	Indianapolis	Marion
Kraft, Haldon C.	Noblesville	Hamilton
Kraft, R. W.	Hobart	Lake
Kramer, A. A.	South Bend	St. Joseph
Kraning, Kenneth	Kewanna	Fulton
Kratzer E. F.	Kokomo	Miami
Kreible, Wm. Wymond	Terre Haute	Vigo
Kremer, Nicholas A.	Madison	Jefferson
Kress, George L.	Hines, Ill.	Kosciusko
Kresler, Leon	Rensselaer	Jasper-Newton
Kretsch, Russell W.	Hammond	Lake
Krueger, Frederick W.	Richmond	Wayne-Union
Kruse, E. H.	Fort Wayne	Allen
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kudele, L. T.	Whiting	Lake
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Hugh A.	Hammond	Lake
Kuhn, R. W.	Wilkinson	Hancock
Kunkler, Joseph	Terre Haute	Vigo
Kunkler, Wm. C.	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurtz, Fred B.	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, I. J.	Indianapolis	Marion
LaBier, C. Russell	Terre Haute	Vigo
LaBier, Clarence R.	Terre Haute	Vigo
LaBonte, Napoleon	Clayton	Marion
Ladig, Donald S.	Fort Wayne	Allen
LaDine, C. B.	Indianapolis	Marion
LaDuron, Jules	Muncie	Delaware-Blackford
LaFata, F. Paul	Springfield, Ill.	Lake
Laird, L. A.	North Webster	Kosciusko

Name	City	County
Lake, G. N.	Pleasant Lake	Steuben
Lamb, E. B.	Indlanapolis	Marion
Lamb, Russell	Indianapolis	Marion
Lamber, C. K.	Indlanapolis	Marion
Lambert, J. L. (H)	Brazil	Clay
Lamey, James L.	Anderson	Madison
Lamey, P. T.	Anderson	Madison
Lane, W. H. (H)	Angola	Steuben
Lane, Wm. H.	South Bend	St. Joseph
Lang, Joseph E.	South Bend	St. Joseph
Lang, Shirley C.	Evansville	Vanderburgh
Langdon, H. K.	Indianapolis	Marion
Langenbahn, C. J.	South Bend	St. Joseph
Langsdon, Fred	Gaston	Delaware-Blackford
Lansford, John	Redkey	Jay
Laramore, Ward	Indianapolis	Marion
Larkin, Bernard J.	Indianapolis	Marion
Larkum, Newton W.	Elkhart	Elkhart
Larmore, J. L.	Anderson	Delaware-Blackford
Larrabee, W. H.	New Palestine	Hancoek
Larrison, G. D.	Moroeco	Jasper-Newton
Larson, G. O.	La Porte	La Porte
LaSalle, R. M.	Wabash	Wabash
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, W. A.	Elwood	Madison
Lauer, A. J.	Whiting	Lake
Lauer, D. B.	Dana	Parke-Vermillion
Lavengood, R. W.	Marion	Grant
Lawler, D. H.	Hammond	Lake
Lawler, George F.	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Laws, H. J.	La Fayette	Tippeeanoe
Laws, Kenneth F.	La Fayette	Tippecanoe
Lawson, I. H.	Kendallville	Noble
Lazo, V. R.	Wheatland	Knox
Leak, Robert H.	La Fayette	Tippecanoe
Leasure, J. K.	Indianapolis	Marion
Leatherman, C. A.	Muncie	Delaware-Blackford
Leatherman, H. L.	Indlanapolis	Marion
LeClaire, Henri	Indianapolis	Morgan
Lee, A. H.	Terre Haute	Vigo
Lec, Glen Ward	Richmond	Wayne-Union
Lee, John M.	Dayton, Ohio	Rush
Leff, Abe	Indianapolis	Marion
Leffel, James M.	Indianapolis	Marion
Lehman, Robert J.	Berne	Marion
Lehmberg, O. F. C.	Columbia City	Whitley
Leich, Charles F.	Evansville	Vanderburgh
Leiter, Arthur	Columbia City	Whitley
Lemmon, B. E.	Indianapolis	Marion
Lemon, Herbert K.	Goshen	Elkhart
Lenk, George G.	Fort Wayne	Allen
Leonard, Henry S.	Indianapolis	Marion
Leser, R. U.	Indianapolis	Marion
Leslie, Ermil	Evansville	Vanderburgh
Lett, Emory B.	Loogootee	Daviess-Martin
Levering, Guy P.	La Fayette	Tippeeanoe
Levi, Leon	Indianapolis	Marion
Levin, Eli	East Chicago	Lake
Lewis, J. R.	Indianapolis	Marion
Lewis, James F.	Liberty	Wayne-Union
Lewis, James L.	Rockville	Parke-Vermillion
Lewis, Robert J.	Lawrenee	Marion
Libbert, E. L.	Indianapolis	Dearborn-Ohio
Libnoch, Casimir	Chicago, Ill.	St. Joseph
Lichtenberg, Melvin	Indianapolis	Marion
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer	New Castle	Henry
Lindenmuth, E. Oscar	Indianapolis	Marion
Lindsay, H. B.	Washington	Davless-Martin
Line, H. E.	Chili	Miami
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, E. L.	Indianapolis	Marion
Link, Goethe	Indianapolis	Marion
Linn, E. E.	La Porte	La Porte
Linton, C. D.	Walkerton	St. Joseph
Linton, C. E.	Medaryville	Pulaski
Linville, Leroy L.	Columbia City	Whitley
Liss, Emanuel C.	South Bend	St. Joseph
List, Harold E.	Marion	Grant
Littell, J. J.	Indianapolis	Marion
Little, J. A.	Evanston, Ill.	Cass
Little, John W.	Indianapolis	Marion
Little, John W., Jr.	Indianapolis	Marion
Litzenberger, S. W.	Anderson	Madison
Lloyd, Robert P.	Fort Wayne	Allen
Lochry, R. L.	Indianapolis	Marion
Lockhart, Jack M.	Louisville, Ky.	Marion
Loehr, W. M.	Indianapolis	Marion
Loewenstein, W. L.	Terre Haute	Vigo
Logan, A. R.	Petersburg	Pike
Logan, F. W.	Mishawaka	St. Joseph
Logan, James Z.	Richmond	Wayne-Union
Logan, Jesse R.	Evansville	Vanderburgh
Lohman, Maurice	Fort Wayne	Allen
Lohman, Robert M.	Fort Wayne	Allen
Lomax, Claude C.	Indianapolis	Marion
Long, J. A. (H)	Anderson	Madison
Long, Leonard	Bluffton	Wells
Long, Max	Marion	Grant
Long, Paul L.	Anderson	Madison
Long, W. H.	Indianapolis	Marion
Loomis, DeWitt	Boonville	Warrick
Loomis, J. F. (H)	St. Petersburg, Fla.	Grant
Loomis, N. S.	Indianapolis	Marion
Loop, Floyd A.	La Fayette	Tippecanoe
Loop, Frederick A.	La Fayette	Tippecanoe
Lord, G. C.	Indianapolis	Marion
Lorenty, T. B.	Gary	Lake
Loring, Mark L.	Valparaiso	Porter
Loudermilk, J. L.	Indianapolis	Marion
Love, George N.	Connersville	Fayette-Franklin
Love, John R.	Terre Haute	Vigo
Loveless, Phillip H.	Phoenix, Ariz.	Hamilton
Lovell, Martin H.	Gary	Lake
Lovett, H. D.	Zionsville	Marion
Loving, J. B.	New Goshen	Vigo
Luckett, C. L.	Bradford, Pa.	Warrick
Luckett, Coen L.	Bradford, Pa.	Vigo
Luckey, H. A.	Wolf Lake	Noble
Luckey, R. C.	Wolf Lake	Noble
Ludwig, Oscar D.	Indianapolis	Marion
Lukemeyer, E. G. (H)	Huntingburg	Dubois
Lukemeyer, L. C. (H)	Huntingburg	Dubois
Lukemeyer, St. John	Jasper	Dubois
Lukenbill, Emery D.	Indianapolis	Marion
Lundt, Milo O.	Elkhart	Elkhart
Lung, B. D.	Kokomo	Howard
Lutes, D. L.	Heltonville	Wayne-Union
Luthy, Karl R.	South Bend	St. Joseph
Lutz, Georgianna	Gary	Lake
Luzadder, J. E.	Bloomington	Monroe
Luzadder, J. E., Jr.	New Carlisle	St. Joseph
Lybrook, D. E.	Young Amerlea	Cass
Lybrook, William B.	Indianapolis	Marion
Lynch, Harold D.	Evansville	Vanderburgh
Lyneh, Otho R.	Richmond	Wayne-Union
Lynch, Otis R.	Louisville, Ky.	Crawford
Lynch, Paul	Evansville	Vanderburgh
Lynn, F. M. (H)	Peru	Miami
Lyon, Florenee	Portland	Jay
Lyons, Charles	Drummond, Mont.	Delaware-Blackford
Lyons, R. E., Jr.	Bloomington	Owen-Monroe
MacBeth, Albert H. (H)	Fort Wayne	Allen
MacDonald, J. A.	Indianapolis	Marion
Maee, E. E.	New Palestine	Hancoek
Macer, Clarence G.	Evansville	Vanderburgh
Mac Gregor, D. E.	Indianapolis	Marion
Machlan, H. F.	Washington, D. C.	Marion
Maehledt, J. H.	Whlteland	Johnson
MacKenzie, Pieree	Evansville	Vanderburgh
Mackey, C. G.	Culver	Marshall
Mackey, John E.	Evansville	Marion
Maey, George	Columbus	Bartholomew-Brown
Mader, John H.	Indianapolis	Marion
Magennis, H. L.	Indianapolis	Marion
Mahoney, Charles L.	Terre Haute	Vigo
Mahuron, Boyd L.	Greensburg	Decatur
Majsterek, S. L.	Gary	Lake
Malcolm, Russell	Riehmond	Wayne-Union
Malmstone, F. A.	Griffith	Lake
Malone, L. A.	Terre Haute	Vigo
Malott, Fred	Converse	Miami
Malouf, S. D.	Peru	Miami
Malstaff, C. M.	South Bend	St. Joseph
Maly, C. H.	Indianapolis	Marion
Manion, Marlow W.	Indianapolis	Marlon
Manley, C. N.	Rising Sun	Dearborn-Ohio
Mann, Mortimer	Indianapolis	Marion
Mansfield, Max R.	Coral Gables, Fla.	Marion
Maple, J. B.	Sullivan	Sullivan
Marchand, Austin F.	Hauhstadt	Gibson
Marchand, Edwin V.	Haubstadt	Gibson
Marcus, Emanuel	Hammond	Lake
Mareus, M. C.	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Markel, I. J.	Elkhart	Elkhart
Markley, H. W.	Rochester	Fulton
Marks, H. H.	Huntington	Huntington
Marks, Ora L.	East Chicago	Lake
Marsh, Chester A.	Hagerstown	Henry
Marsh, George W.	La Fayette	Tippecanoe
Marshall, A. L.	Indianapolis	Marion
Marshall, Augustus L.	Indianapolis	Marion
Marshall, B. W.	Nashville	Bartholomew-Brown
Marshall, C. R.	Indianapolis	Marlon
Marshall, George	Bourbon	Marshall
Marshall, L. C.	Mount Summit	Henry
Marshall, T. J.	Charlestown	Clark
Marshall, William P.	Kalamazoo, Mich.	Marion
Martin, C. E.	Lynn	Randolph
Martin, Frank D.	Bedford	Lawrence
Martin, Floyd S.	Goshen	Elkhart
Martin, Guy	Seymour	Jaekson
Martin, Harold R.	La Fayette	Tippeeanoe
Martin, Hugh E.	Indianapolis	Marion
Martin, H. G.	La Fayette	Tippeeanoe
Martin, Joe M.	La Fayette	Tippeeanoe
Martin, L. H.	Indianapolis	Marion
Martin, W. B.	La Porte	La Porte
Martin, Will J.	Kokomo	Howard
Martz, Carl D.	Indianapolis	Marion
Mason, Bernard	South Bend	St. Joseph
Mason, Everett E.	Evansville	Vanderburgh
Mason, L. R.	Muncie	Delaware-Blaekford
Mast, Karl F.	Angola	Allen
Masters, John B.	Indianapolis	Marion
Masters, J. M.	Indianapolis	Marion
Masters, R. J.	Indianapolis	Marion
Mather, J. W.	East Gary	Lake
Mathews, W. C.	Kentland	Jasper-Newton
Mathys, Alfred	Mauekport	Harrison
Matthew, W. B.	Indianapolis	Marion
Matthews, B. J.	Indianapolis	Marion
Matthews, Chas. B.	Hammond	Lake
Matthews, D. W.	North Vernon	Jennings
Mattox, Don M.	Terre Haute	Vigo
Maurer, J. F.	Brazil	Clay

Name	City	County
Maurer, Robert M.	Brazil	Clay
Mavity, D. E. (H)	Fowler	Benton
Maxwell, J. B. (H)	Logansport	Cass
May, George A.	Madison	Jefferson
May, R. M.	Gary	Lake
Mayfield, C. H.	Reynolds	Tippecanoe
McArdle, Edward G.	Fort Wayne	Allen
McBride, E. C.	Terre Haute	Vigo
McBride, James S.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCabe, J. E.	Otterbein	Benton
McCabe, Theodore E.	Fort Wayne	Allen
McCallum, Joseph T. C.	Indianapolis	Marion
McCarthy, F. G.	Terre Haute	Vigo
McCarthy, Jeremiah A.	Whiting	Lake
McCartney, Donald H.	Fairmount	Marion
McCarty, Virgil	Princeton	Gibson
McCaskey, C. H.	Indianapolis	Marion
McCaskey, G. H.	Winamac	Pulaski
McCay, O. L.	Romney	Tippecanoe
McClain, Marvin	Scottsburg	Scott
McClellan, John B.	Muncie	Tippecanoe
McClelland, D. C.	La Fayette	Tippecanoe
McClintock, James A.	Louisville, Ky.	Delaware-Blackford
McClure, S. E.	Monon	Tippecanoe
McConnell, Wm. C.	Sunman	Ripley
McCool, J. H.	Evansville	Vanderburgh
McCool, W. E. (H)	Evansville	Vanderburgh
McCord, C. B.	Veedersburg	Fountain-Warren
McCormick, C. O., Sr.	Indianapolis	Marion
McCormick, C. O., Jr.	Indianapolis	Marion
McCormick, H. D.	Vincennes	Knox
McCormick, W. C.	Terre Haute	Vigo
McCown, P. E.	Indianapolis	Marion
McCoy, Roy R.	Fort Wayne	Allen
McCracken, J. O.	Montgomery	Daviess-Martin
McCraley, William J.	South Bend	St. Joseph
McCulloch, C. B.	Indianapolis	Marion
McCullough, J. Y.	New Albany	Floyd
McDaniel, F. P.	Atlanta	Hamilton
McDevitt, D. R.	Indianapolis	Marion
McDonald, J. D.	Evansville	Vanderburgh
McDonald, R. M.	South Bend	St. Joseph
McDonald, V. G.	Anderson	Madison
McDowell, George A.	Fort Wayne	Allen
McDowell, M. M.	Vincennes	Knox
McElroy, J. S.	New Castle	Henry
McElroy, R. S.	Princeton	Gibson
McEwen, J. W.	Terre Haute	Vigo
McFadden, James M.	La Fayette	Allen
McFall, V. F.	Anderson	Madison
McFarland, Corley B.	South Bend	St. Joseph
McGaughey, W. M.	Greencastle	Putnam
McGuire, D. F.	East Chicago	Lake
McIlwain, Eleanor	Marion	Grant
McIlwain, Robert	Marion	Grant
McIndoo, R. E	Kokomo	Howard
McIntosh, Wilbert	Cory	Marion
McIntyre, Charles J.	Indianapolis	Marion
McIntyre, J. M.	Indianapolis	Marion
McKay, J. D. (H)	Marion	Grant
McKean, T. J.	Montpelier	Adams
McKee, C. E. (H)	Dublin	Wayne-Union
McKee, H. S.	Greensburg	Decatur
McKeeman, D. H.	Fort Wayne	Allen
McKeeman, L. S.	Fort Wayne	Allen
McKenna, H. J.	South Bend	St. Joseph
McKinley, A. D.	Indianapolis	Marion
McKinley, Joseph	Lafayette	Tippecanoe
McKinney, D. H.	La Fayette	Tippecanoe
McKinney S. L.	Huntingburg	Dubois
McKinstray, H. R.	Indianapolis	Marion
McKittrick, Jack	Washington	Daviess-Martin
McKittrick, Wm. O.	Washington	Daviess-Martin
McLaughlin, C. P.	Pendleton	Madison
McLaughlin, G. C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McMahan, Virgil	Vincennes	Knox
McMeel, J. E.	South Bend	St. Joseph
McMichael, F. J.	Gary	Lake
McMichael, R. M.	Muncie	Delaware-Blackford
McMillan, F. G.	Indianapolis	Marion
McMurtry, L. K.	Corpus Christi, Texas	Vanderburgh
McNabb, G. B.	Carthage	Rush
McNaughton, L. M.	Washington	Daviess-Martin
McNaull, Charles (H)	Indianapolis	Marion
McNeely, M. J.	Dillsboro	Dearborn-Ohio
McPherson, S. L. (H)	Washington	Daviess-Martin
McQueen, William	Jamestown, N. C.	Marion
McQuiston, R. J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVaugh, Charles C.	Pendleton	Madison
McVey, C. A.	Hammond	Lake
McWilliams, W. B.	Liberty	Wayne-Union
Mead, C. H.	Bluffton	Wells
Meade, W. W.	Bicknell	Knox
Medcalf, N. L.	Lamar	Spencer
Mengenhardt, D. S.	Indianapolis	Marion
Mehl, Rudolph A.	Evansville	Vanderburgh
Meikle, Louise J.	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiner, J. A.	Kokomo	Howard
Meiser, Robert	Huntington	Huntington
Meister, Doris	Anderson	Madison
Melloh, A. F.	Indianapolis	Marion
Mendenhall, C. D.	Indianapolis	Marion
Mendenhall, Edgar	Fort Wayne	Allen
Mendenhall, W. E.	Indianapolis	Marion
Mentendiek, M. H.	Indianapolis	Marion
Mendez, Carlos	Elkhart	Elkhart
Menza, Micbael J.	Buffalo, N. Y.	Johnson
Mercer, Samuel R.	Fort Wayne	Allen
Merchant, Raymond	Lake Village	Jasper-Newton
Meredith, E. J.	Richmond	Wayne-Union
Mericle, Earl	Indianapolis	Marion
Merrell, B. M.	Rockville	Jackson
Merrell, Paul	Indianapolis	Marion
Mertz, H. O.	Indianapolis	Marion
Mervis, F. H.	East Chicago	Lake
Messer, F. W.	Kendallville	Noble
Metcalf, George B.	Anderson	Madison
Metcalfe, G. E.	South Bend	St. Joseph
Meyer, Herman A.	Fort Wayne	Allen
Meyer, K. T.	Evansville	Vanderburgh
Meyer, R. C.	Vincennes	Knox
Michael, Amos C.	Indianapolis	Marion
Michaelis, S. C.	Fort Wayne	Allen
Michaels, J. F.	Edinburg	Johnson
Micheli, A. J.	Indianapolis	Marion
Middleton, H. N.	Indianapolis	Madison
Mikesch, W. H.	South Bend	St. Joseph
Miller, Albert W.	Indianapolis	Marion
Miller, Carl G.	Fort Wayne	Allen
Miller, Charles A.	Princeton	Gibson
Miller, D. B.	Terre Haute	Vigo
Miller, E. H.	Valparaiso	Porter
Miller, H. A.	Marion	Grant
Miller, H. L.	West Baden	Orange
Miller, Harold E.	Seymour	Jackson
Miller, Henry P.	Fort Wayne	Allen
Miller, Jack B.	Cleveland, O.	Pike
Miller, J. Don	Indianapolis	Marion
Miller, L. B.	Evansville	Vanderburgh
Miller, L. R.	Winslow	Pike
Miller, M. E.	Goshen	Elkhart
Miller, Mahlon F.	Fort Wayne	Allen
Miller, Milton	Evansville	Vanderburgh
Miller, Milo	South Bend	St. Joseph
Miller, Minor	Evansville	Vanderburgh
Miller, Orval J.	Fort Wayne	Allen
Miller, Raymond D.	Indianapolis	Marion
Miller, R. S.	Indianapolis	Marion
Miller, Richard C.	Shelbyville	Marion
Miller, Richard H.	Fort Wayne	Allen
Miller, Robert J.	Evansville	Vanderburgh
Miller, Roland E.	Indianapolis	Marion
Miller, S. J.	West Lafayette	Tippecanoe
Miller, S. T.	Elkhart	Elkhart
Miller, Virgil	Akron	Fulton
Miller, Wm. A.	Hagerstown	Henry
Miller, Wm. E.	South Bend	St. Joseph
Miller, Wm. T.	Indianapolis	Marion
Millikan, William	Indianapolis	Marion
Millis, Robert	Crawfordsville	Montgomery
Mills, J. F.	Wabash	Henry
Minczewski, Richard C.	Gary	Lake
Mino, Victor H.	Evansville	Vanderburgh
Mirro, John A.	Lowell	Lake
Mishkin, Irving	Elkhart	Elkhart
Mitchell, Albert M.	Terre Haute	Vigo
Mitchell, E. T.	Romney	Tippecanoe
Mitchell, Earl H.	Indianapolis	Marion
Mitchell, G. L.	Smithville	Monroe
Mitchell, H. F. (H)	South Bend	St. Joseph
Mitchell, J. I.	Salem	Washington
Mitchell, R. E.	Indianapolis	Marion
Mitman, F. B.	Huntington	Huntington
Moats, C. F.	Fort Wayne	Allen
Moats, G. E.	Fort Wayne	Allen
Mock, E. L.	New Orleans	Knox
Modisett, Jackson W.	Madison	Jefferson
Modisett, Marcella S.	Madison	Jefferson
Modjeski, Joseph R.	Calumet City, Ill.	Lake
Modjeski, Raymond J.	Hammond	Lake
Moehlenkamp, C. E.	Evansville	Vanderburgh
Moenning, W. P.	Indianapolis	Marion
Mohr, Ann L. M.	Shelbyville	Shelby
Molloy, W. J.	Muncie	Delaware-Blackford
Molt, W. F.	Indianapolis	Marion
Montgomery, J. R.	Owensville	Gibson
Montgomery, L. G.	Muncie	Delaware-Blackford
Montgomery, S B.	Cynthiana	Posey
Montgomery, Wm. F.	Indianapolis	Marion
Moore, B. B.	Indianapolis	Marion
Moore, H. T.	Indianapolis	Marion
Moore, Martha	Madison	Jefferson
Moore, R. G.	Vincennes	Knox
Moore, Robert M.	Indianapolis	Marion
Moore, W. C.	Muncie	Delaware-Blackford
Moosey, Louis	Union Mills	La Porte
Moran, Mark M.	Portland	Jay
Moran, Noel D.	Versailles	Ripley
Moravec, Arthur E.	Fort Wayne	Allen
Morford, Guy	Muncie	Delaware-Blackford
Morgan, Isabel	Ann Arbor, Michigan	Hendricks
Morgan, Marion M.	Youngstown, Ohio	Vanderburgh
Morgan, S. P.	La Porte	La Porte
Moriarty, John R.	Indianapolis	Marion
Morr, J. W.	Albion	Noble
Morrical, Russell J.	Wolcott	Jasper-Newton
Morris, G. B.	Bluffton	Wells
Morris, J. B.	Boise, Idaho	Lake
Morris, J. W.	Hartford City	Delaware-Blackford
Morris, Marion H.	Philadelphia, Pa.	Marion
Morris, W. F.	Fort Branch	Gibson
Morris, Warren V.	Monticello	Tippecanoe
Morrison, C. C.	Greensburg	Decatur
Morrison, D. A.	Kokomo	Howard
Morrison, G. G.	Portland	Jay
Morrison, John S. (H)	La Fayette	Tippecanoe
Morrison, J. T.	Greensburg	Decatur
Morrison, Lindsey	Hammond	Lake
Morrison, Lewis E. II	Indianapolis	Marion
Morrison, W. R.	Kokomo	Howard
Morrow, R. D.	Connersville	Fayette-Franklin
Mortenson, L. J.	Fort Wayne	Allen

Name	City	County
Morton, Walter P.	Indianapolis	Marion
Moser, E. B.	Windfall	Tipton
Moser, Edward	Woodburn	Allen
Moser, R. H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Spokane, Wash.	Greene
Moss, Harlan B.	Address Unknown	Lake
Moss, M. J.	Yorktown	Delaware-Blackford
Mothersill, M. H.	Indianapolis	Marion
Mott, C. A.	South Bend	St. Joseph
Moulton, Lillian	Indianapolis	Marion
Mount, M. S.	Bloomfield	Greene
Mount, Wm.	Crawfordsville	Montgomery
Mount, Wm. C.	Kirklin	Clinton
Mountain, Francis	Connersville	Fayette-Franklin
Moutoux, J. E.	Indianapolis	Marion
Mozingo, A. E.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Lawrence	Fort Wayne	Allen
Mueller, Lillian B.	Indianapolis	Marion
Muhleman, C. E.	La Porte	La Porte
Mulcaby, B. J.	Muncie	Delaware-Blackford
Mull, P. L.	Louisville, Ky.	Washington
Muller, Lullus P.	Boswell	Marion
Mullikin, C. W.	Greensburg	Decatur
Mullikin, H. M.	Terre Haute	Vigo
Mullin, H. Y.	Rockfield	Carroll
Mumford, E. B.	Indianapolis	Marion
Muncie, H. L.	Brazil	Clay
Munk, C. E.	Kendallville	Noble
Muntz, Hascall H.	Indianapolis	Marion
Murdock, H. L.	Fort Wayne	Allen
Murphy, E. C.	South Bend	St. Joseph
Murphy, E. W.	Lanesville	Harrison
Murphy, Harry	Franklin	Johnson
Murphy, Josephine	South Bend	St. Joseph
Murphy, M. G.	Morgantown	Morgan
Murray, F. N.	Kokomo	Howard
Musselman, G. G.	Terre Haute	Vigo
Myers, B. D.	Bloomington	Owen-Monroe
Myers, Charles W.	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion
Myers, Wm. C.	Dana	Parke-Vermillion
Nafe, C. A.	Indianapolis	Marion
Nahrwold, Elmer W.	Fort Wayne	Allen
Nakadate, Katsumi J.	East Chicago	Lake
Nance, W. K.	Vincennes	Knox
Napper, Floyd	Scottsburg	Scott
Nash, Charles B.	Valparaiso	Porter
Nash, Justin R.	Albion	Noble
Nason, R. A.	Garrett	De Kalb
Naugle, R. A.	Wabash	Wabash
Nave, H. E.	Fountaintown	Shelby
Navin, Hugh K.	Fortville	Hancock
Nay, E. O.	Terre Haute	Vigo
Need, Louis T.	Indianapolis	Marion
Neely, A. S.	Indianapolis	Marion
Nehil, L. W.	Indianapolis	Marion
Neidballa, E. G.	Bristol	Elkhart
Neier, O. C. (II)	Indianapolis	Marion
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Paul Leon	Anderson	Madison
Nelson, R. B.	Hammond	Lake
Nelson, Raymond	South Bend	St. Joseph
Nelson, Wnlfred A.	Gary	Lake
Nenneker, Henry	Evansville	Vanderburgh
Nesbit, L. L.	Anderson	Madison
Nesbit, O. B.	Gary	Lake
Nestmann, Ralph H.	Indianapolis	Marion
Netherton, C. R.	Chalmers	Tippecanoe
Neumann, K. O.	La Fayette	Tippecanoe
Neuwalt, Frank	Gary	Lake
Newby, A. C.	Sheridan	Hamilton
Newcomb, Wm. K.	Royal Center	Cass
Newland, A. E.	Bedford	Lawrence
Newman, A. E.	Evansville	Vanderburgh
Niblack, E. S.	Terre Haute	Vigo
Niblack, J. S.	East Chicago	Lake
Nickel, Allen C.	Bluffton	Wells
Nicosia, J. B.	East Chicago	Lake
Nie, Grover	Huntington	Huntington
Nie, Louis W.	Indianapolis	Huntington
Niedermeyer, Alfred	Evansville	Vanderburgh
Nigh, R. M.	Fairland	Shelby
Nill, John H.	Fort Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Nixon, J. E.	Portland	Jay
Noble, T. B., Sr.	Indianapolis	Marion
Noble, T. B., Jr.	Indianapolis	Marion
Noblitt, J. S.	Rockville	Montgomery
Nodinger, Louis	Hammond	Lake
Noe, Joseph T.	East Chicago	Lake
Nolt, E. V.	Columbia City	Whitley
Nolting, H. F.	Indianapolis	Marion
Nonte, Leo R.	Indianapolis	Marion
Norman, O. B.	Indianapolis	Marion
Norman, Wm. H.	Indianapolis	Marion
Norris, Allen A.	Elkhart	Elkhart
Norris, Ernest B.	Middlebury	Elkhart
Norris, H. L.	Indianapolis	Marion
Norris, Mary A.	Indianapolis	Marion
Norton, H. J.	Columbus	Bartholomew-Brown
Norton, Horace	Crane	Marion
Norton, Wm. J. (II)	Columbus	Bartholomew-Brown
Norwick, Sydney	Ann Arbor, Mich.	Marion
Nourse, Myron H.	Corona, Calif.	Marion
Nugen, Harold	Auburn	De Kalb
Nutter, Wyndham H.	Rushville	Rush
Nyce, Holst Wm.	Van Buren	Grant
Oak, D. D.	La Crosse	La Porte
Obery, George	Batesville	Fayette-Franklin
O'Brien, Tracy	Danville	Putnam
Ochsner, Harold C.	Indianapolis	Marion
O'Connor, James J.	East Chicago	Lake
O'Dell, Harry C.	Farmersburg	Sullivan
O'Dell, Harry W.	Jersey City, N. J.	Sullivan
O'Dell, Thomas A.	Indianapolis	Marion
O'Hale, John A.	Richmond	Wayne-Union
Olcott, C. W.	Aurora	Dearborn-Ohio
O'Leary, F. T.	Logansport	Cass
Oliphant, F. W.	Mount Vernon	Posey
Oliphant, J. T.	Farmersburg	Sullivan
Oliphant, R. W.	Terre Haute	Vigo
Oliver, E. W.	Evansville	Vanderburgh
Olson, K. L.	South Bend	St. Joseph
Olvey, Ottis N.	Indianapolis	Hamilton
Omstead, Trevalyn W.	Andrews	Huntington
O'Neil, Martin J.	Demotte	Jasper-Newton
Openshaw, J. F.	Goodland	Tippecanoe
Oppenheimer, Ernst	Evansville	Vanderburgh
Orders, C. E.	Indianapolis	Marion
O'Rourke, Carroll	Fort Wayne	Allen
Orr, William R.	Mishawaka	St. Joseph
Osborne, Harry S.	Roachdale	Marion
Osterman, Louis	Seymour	Jackson
Ostrowski, L. J.	East Chicago	Lake
Ostrowski, R. O.	Hammond	Lake
Oswalt, J. T.	Dunkirk	Clay
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Ottinger, R. C.	Indianapolis	Marion
Otto, Anthony E. (H)	Alexandria	Madison
Overman, F. V.	Tipton	Tipton
Overmyer, Jay W.	Winchester	Randolph
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman	Columbus	Bartholomew-Brown
Owen, Abraham	Bloomington	Owen-Monroe
Owen, J. E.	Indianapolis	Marion
Owen, Margaret T.	Bloomington	Owen-Monroe
Owens, John B.	Houston, Tex.	Fountain-Warren
Owens, Richard R.	Muncie	Delaware-Blackford
Owens, Thomas R.	Muncie	Delaware-Blackford
Owens, Tracy	Indianapolis	Marion
Owsley, Charlotte	Hartford City	Delaware-Blackford
Owsley, Guy A.	Hartford City	Delaware-Blackford
Owsley, G. M.	Thorntown	Boone
Owsley, Robert	Los Angeles, Calif.	Delaware-Blackford
Oyer, J. H.	Fort Wayne	Allen
Pace, J. V.	New Albany	Floyd
Padgett, E. E.	Indianapolis	Marion
Paff, W. A.	Elkhart	Elkhart
Pahmeier, J. W.	Sandborn	Knox
Painter, L. W.	Winchester	Randolph
Palm, John M.	Brazil	Clay
Palmer, Earl	Logansport	Cass
Palmer, Russell H.	Gary	Lake
Panares, Solomon V.	Hammond	Lake
Pancost, Ruth M. Hoetzer	Elkhart	Allen
Pancost, Vernon K.	Elkhart	Elkhart
Pandolfo, Harry	Indianapolis	Marion
Paris, D. W.	Kokomo	Howard
Paris, J. M.	New Albany	Floyd
Parke, D. Davis	Indianapolis	Delaware-Blackford
Parker, Carl B.	Wingate	Montgomery
Parker, C. B.	Fort Wayne	Allen
Parker, Earl E.	Mishawaka	St. Joseph
Parker, E. E.	Oxford	Benton
Parker, G. F.	Greencastle	Putnam
Parker, H. C.	Gary	Lake
Parker, H. P.	Urbana	Wabash
Parker, J. F.	Indianapolis	Marion
Parker, John T.	Gary	Lake
Parker, Portia	Indianapolis	Marion
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Patrick, G. B.	Elkhart	Elkhart
Patten, V. C.	Morristown	Shelby
Patterson, William K.	Anderson	Madison
Patton, Martin T.	Indianapolis	Marion
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Payne, A. C.	East Chicago	Lake
Paynter, L. W.	Salem	Washington
Paynter, Morris B.	Southport	Marion
Peacock, Norman F.	Crawfordsville	Montgomery
Peacock, Robert	Dunkirk	Marion
Pearce, Roy V.	Franklin	Marion
Pearlman, Samuel	La Fayette	Tippecanoe
Pearson, John R.	Bedford	Lawrence
Pearson, Lyman R.	Indianapolis	Marion
Pearson, Wm. E.	Wabash	Wabash
Pebworth, A. C.	Indianapolis	Marion
Pebworth, J. T.	Indianapolis	Marion
Peck, Franklin B.	Indianapolis	Marion
Pectol, Charles F.	Spencer	Owen-Monroe
Peirce, James D.	Indianapolis	Marion
Pekarek, Edward A.	Whiting	Lake
Pell, H. M.	Brazil	Clay
Pence, Benjamin F.	Columbia City	Whitley
Pennington, W. E.	Indianapolis	Marion
Pentecost, Paul S.	Richmond	Wayne-Union
Permer, Erwin	Indianapolis	Marion
Perrin, K. F.	Fort Wayne	Allen
Perry, F. G.	Plymouth	Marshall
Peters, R. J. D.	Indianapolis	Marion
Peterson, Joel A.	Lafayette	Tippecanoe
Petitjean, H. G.	Haubstadt	Gibson
Petranoff, T. V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph
Petronella, S. J.	East Chicago	Lake
Pettibone, C. R.	Crown Point	Lake
Pettijohn, F. L.	Indianapolis	Marion
Peyton, Frank W.	La Fayette	Tippecanoe
Pfaff, Dudley	Indianapolis	Marion
Pfaff, John A.	Indianapolis	Marion
Pfafflin, C. A.	Indianapolis	Marion

Name	City	County
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Phillips, W. R.	Glenwood	Fayette-Franklin
Phipps, D. L. (H)	Union City	Johnson
Phipps, Leland K.	Union City	Randolph
Piazza, Leonard F.	Michigan City	La Porte
Pierce, H. J.	Terre Haute	Vigo
Pierson, P. R.	New Albany	Floyd
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pilcher, Jack	Indianapolis	Marion
Pilot, Jean	Hammond	Lake
Piper, Mark	New Castle	Henry
Pippenger, W. G.	Brook	Jasper-Newton
Pirkle, H. B.	Rockville	Parke-Vermillion
Pitkin, Edward M.	Martinsville	Morgan
Pitkin, M. C.	Martinsville	Morgan
Plain, George	South Bend	St. Joseph
Ploughe, Monroe L. (H)	Elwood	Madison
Ploughe, R. R.	Elwood	Madison
Polhemus, Gretchen I.	New Albany	Floyd
Pollak, Lewis	Indianapolis	Marion
Pollard, Walter	Evansville	Vanderburgh
Pollom, Robert R.	Crawfordsville	Montgomery
Pomeroy, Rex K.	Plymouth	Marshall
Popp, M. F.	Fort Wayne	Allen
Porter, Carl M.	Jasonville	Greene
Porter, E. A.	Westport	Decatur
Porter, George C.	Linton	Greene
Porter, John R.	Lebanon	Boone
Porter, Mac Guyer (H)	Elnora	Daviess-Martin
Porter, M. F.	Fort Wayne	Allen
Porter, W. L.	Oxford, O.	Wayne-Union
Portteus, Walter L.	Franklin	Johnson
Possolt, T. R.	Plymouth	Marshall
Post, Edward S.	Marion	Grant
Poston, C. L.	Richmond	Wayne-Union
Powell, E. H.	Valparaiso	Porter
Powell, J. Paxton	Marion	Marion
Powell, Nettie B. (H)	Marion	Grant
Premuda, F.E.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson
Prentiss, Nelson H.	Fort Wayne	Allen
Present, Julian	Evansville	Vanderburgh
Price, Douglas	Nappanee	Elkhart
Price, Ernest H.	Danville	Hendricks
Price, James O.	Indianapolis	Marion
Price, Melvin D.	Nappanee	Elkhart
Price, Sidney	Marion	Grant
Price, W. A. (H)	Nappanee	Elkhart
Proudfit, Charles H.	Mishawaka	St. Joseph
Prough, W. A.	Indianapolis	Marion
Province, O. A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pryor, R. C.	Indianapolis	Marion
Przednowek, A. C.	La Porte	La Porte
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, B. H.	Wolcottville	Noble
Puryear, J. O.	Gary	Lake
Puterbaugh, K. E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph
Quick, Wm. J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (H)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
Rabb, Harry	Indianapolis	Marion
Rabson, S. Milton	Fort Wayne	Allen
Ragsdale, H. C.	Bedford	Lawerence
Rainey, E. A.	Lebanon	Boone
Ralston, John D.	Indianapolis	Marion
Ramage, W. F.	Beech Grove	Marion
Ramsay, J. P. (H)	Vincennes	Knox
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, H. S.	Bloomington	Owen-Monroe
Randall, Karl C. II	Pittsburgh, Pa.	Tippecanoe
Ranes, J. R.	Mount Vernon	Posey
Raney, B. B.	Linton	Greene
Rang, A. A.	Washington	Daviess-Martin
Ranke, John W. H. (H)	Fort Wayne	Allen
Raphael, Isidor J.	Evansville	Vanderburgh
Rarick, Alden J.	Nashville, Tenn.	Noble
Rarlden, L. B.	Greenfield	Hancock
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, A. L.	Kingman	Fountain-Warren
Ratcliff, Frank W.	La Fayette	Tippecanoe
Ratcliffe, A. W.	Evansville	Vanderburgh
Rauschenbach, C. W.	Hammond	Lake
Ravdin, Bernard	Evansville	Vanderburgh
Ravdin, Marcus (H)	Evansville	Vanderburgh
Rawles, Lyman T.	Fort Wayne	Allen
Ray, H. A.	Fort Wayne	Allen
Rayl, C. C.	Decatur	Adams
Reck, J. L.	Sheridan	Hamilton
Records, A. W.	Franklin	Johnson
Redding, Lowell G.	Detroit, Mich.	Huntington
Reed, Ann	Michigan City	La Porte
Reed, Donald	Culver	Marshall
Reed, J. V.	Indianapolis	Marion
Reed, L. D. (H)	Hope	Bartholomew-Brown
Reed, Nelle C.	Michigan City	La Porte
Reed, Philip B.	Indianapolis	Marion
Reed, R. R.	Anderson	Marion
Reed, Wm. C.	Bloomington	Owen-Monroe
Reeder, H. H.	Jeffersonville	Clark
Rees, Russell C.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Chas. A.	Indianapolis	Marion
Reid, Robert W.	Union City	Randolph
Reilly, James F.	Vincennes	Knox
Reisler, Simon	Indianapolis	Marion
Reiss, Jack	Indianapolis	Marion
Reitz, Thomas F.	Evansville	Vanderburgh
Remich, A. C.	Hammond	Lake
Renbarger, L. L.	Marion	Grant
Rendel, C. F.	Mexico	Miami
Rendel, D. T.	Hammond	Lake
Rendel, H. E.	Mexico	Miami
Rentschler, L. C.	Clay City	Clay
Reppert, Roland	Decatur	Adams
Resch, Frederick A.	Youngstown, Ohio	Wells
Rettig, A. C.	Muncie	Delaware-Blackford
Reul, Thomas W.	Summit, N. J.	Marion
Reusser, Amos (H)	Berne	Adams
Reynolds, D. M.	Garrett	De Kalb
Reynolds, F. C.	St. Louis, Mo.	Marion
Reynolds, J. S.	Gary	Lake
Reynolds, R. P.	Garrett	De Kalb
Rhany, A. P.	Wabash	Wabash
Rhamy, B. W.	Fort Wayne	Allen
Rhea, G. D.	Greencastle	Putnam
Rhea, James C.	Beech Grove	Marion
Rhind, A. W.	Hammond	Lake
Rhodes, A. H.	Princeton	Gibson
Rhodes, Theodore D.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rhorer, R. J.	Midland, Texas	Howard
Rice, Raymond M.	Indianapolis	Marion
Rice, Thurman B.	Indianapolis	Marion
Rice, T. R. (H)	Petersburg	Pike
Rice, W. B.	Fort Wayne	Allen
Rich, J. S.	Evansville	Vanderburgh
Richard, Norman F.	Shelbyville	Shelby
Richards, D. H.	Vincennes	Knox
Richards, E. E.	Russellville	Montgomery
Richardson, C. L.	Rochester	Fulton
Richart, J. V.	Terre Haute	Vigo
Richer, O. H.	Warsaw	Kosclusko
Richey, Clifford	Evansville	Vanderburgh
Richter, Arthur B.	Indianapolis	Marion
Richter, Samuel	Gary	Lake
Ricketts, J. W.	Indianapolis	Marion
Ridgway, Alton H.	Indianapolis	Marion
Ridgeway, O. W.	Indianapolis	Marion
Rigg, J. F.	Indianapolis	Marion
Riggs, Floyd	Terre Haute	Vigo
Rigley, E. L.	South Bend	St. Joseph
Riley, E. T. (H)	Greensburg	Decatur
Riley, Frank	Jamestown	Boone
Rinker, E. B.	Indianapolis	Marion
Rinne, John I.	Lapel	Madison
Rissing, Walter J.	Fort Wayne	Allen
Ritchey, J. A.	West Salem, Ore.	Grant
Ritchey, J. O.	Indianapolis	Marion
Ritter, Wayne L.	Indianapolis	Marion
Ritz, Albert S.	Evansville	Vanderburgh
Roberts, Floyd N.	Prescott, Arizona	Henry
Robertson, A. N.	New Albany	Floyd
Robertson, D. W. (H)	Deputy	Jennings
Robertson, M. O.	Bedford	Lawrence
Robertson, Ray	Indianapolis	Marion
Robertson, W. S.	Spiceland	Henry
Robinson, Earl U.	Evansville	Vanderburgh
Robinson, Frank C.	St. Petersburg, Fla.	Marion
Robison, C. A.	Frankfort	Clinton
Robison, J. S.	Winchester	Randolph
Robrock, Lawrence M.	Michigan City	La Porte
Rockey, Noah A.	Fort Wayne	Allen
Rodenbeck, Frank	Arcadia	Hamilton
Rodin, Herman H.	South Bend	St. Joseph
Rodriguez, Juan	Fort Wayne	Allen
Rogers, Evered E.	Auburn	De Kalb
Rogers, O. F.	Bloomington	Owen-Monroe
Rogers, R. C.	Bloomington	Owen-Monroe
Rogers, S. T. (H)	New Albany	Floyd
Rogers, Thomas P.	Indianapolis	Marion
Rohmer, Ralph G.	Mitchell	Lawrence
Rohrer, J. R.	Elnora	Daviess-Martin
Roll, E. C.	Indianapolis	Marion
Roller, C. W.	Indianapolis	Marion
Rollins, Russell	Royal Center	Cass
Romack, H. H.	Cambridge, N. Y.	Hancock
Romberger, Floyd T.	La Fayette	Tippecanoe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Rommel, Clarence H.	West Lafayette	Tippecanoe
Ropp, E. R.	Oakland City	Gibson
Ropp, H. E.	New Harmony	Posey
Rose, Bertha	West Lafayette	Tippecanoe
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, L. E.	Anderson	Madison
Rosenblatt, B. B.	Evansville	Vanderburgh
Rosenbloom, P. J.	Gary	Lake
Rosenfeld, Norman B.	Clinton	Parke-Vermillion
Rosenheimer, Geo. M.	South Bend	St. Joseph
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, A. J.	Fort Wayne	Allen
Rosevear, Henry J.	Hammond	Lake
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, Guy E.	Anderson	Madison
Ross, H. P.	Richmond	Wayne-Union
Ross, L. F.	Richmond	Wayne-Union
Ross, W. W.	La Porte	La Porte
Rossiter, D. L.	Fort Wayne	Allen
Rossow, R. J.	Evansville	Vanderburgh
Rothberg, Maurice	Fort Wayne	Allen
Rothschild, C. J.	Fort Wayne	Allen
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam	Jasonville	Greene
Row, D. H.	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perry Q.	Hammond	Lake
Rowe, Howard H.	Rochester	Fulton
Royster, George M.	Evansville	Vanderburgh

Name	City	County
Royster, Hollace R.	Frankfort	Clinton
Royster, R. A.	Evansville	Vanderburgh
Rozelle, Clarence V.	Anderson	Madison
Rubens, Eli	South Bend	St. Joseph
Rubin, Gerald S.	Indianapolis	Marion
Rubin, M. R.	Gary	Lake
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Ruby, Fred McKemy	Union City	Randolph
Rueh, Monroe K.	Pasadena, Calif.	Marion
Ruddell, Karl R.	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Ruddick, H. C.	Evansville	Vanderburgh
Rudesill, C. L.	Indianapolis	Marion
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, F. G.	Hammond	Lake
Rudolph, Stephen, Jr.	Philadlephia, Pa.	Marion
Rudser, D. H.	Whiting	Lake
Ruhmkorff, Ralph H.	Goodland	Jasper-Newton
Rupel, Ernest	Indianapolis	Marion
Ruschli, E. B.	La Fayette	Tippecanoe
Rusk, Hubert M.	Wallace	Fountain-Warren
Russell, O. Raymond	Frankton	Madison
Russo, John G.	Kaukauna, Wis.	Lake
Rust, Byron K.	Indianapolis	Marion
Rustin, Edward	South Bend	St. Joseph
Ruth, Martin L.	Indianapolis	Marion
Rutherford, C. W.	Indianapolis	Marion
Ryan, Glen V.	Indianapolis	Marion
Ryan, H. J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown
Sage, Charles V., Jr.	Richmond	Marion
Sage, Russell	Indianapolis	Marion
Sagel, Jacob	Gary	Lake
Sahlmann, Hans	Fort Wayne	Allen
Sala, J. J.	Gary	Lake
Salb, John A.	Indianapolis	Marion
Salb, Leo A.	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Sales, Louis M.	Indianapolis	Marion
Salon, Harry W.	Fort Wayne	Allen
Salon, N. L.	Fort Wayne	Allen
Salzman, Morris	Indianapolis	Marion
Samples, J. T.	Boonville	Warrick
Sanders, I. M.	Greensburg	Decatur
Sanders, J. A.	Auburn	De Kalb
Sanderson, R. B.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph
Sandock, Louis	South Bend	St. Joseph
Sandorf, M. H.	Indianapolis	Marion
Sandoz, Harry	South Bend	St. Joseph
Sandoz, Louis A.	South Bend	St. Joseph
Sandy, Wm. A.	Indianapolis	Marion
Saunders, J. L.	Newport	Parke-Vermillion
Savage, A. R.	Fort Wayne	Allen
Savery, C. E.	South Bend	St. Joseph
Sayers, F. E.	Terre Haute	Vigo
Scales, A. B.	Evansville	Gibson
Scamahorn, Malcolm O.	Indianapolis	Hendricks
Scamahorn, O. T.	Pittsboro	Hendricks
Scantland, Willard A.	Richmond	Delaware-Blackford
Schaaf, Alvin	Jamestown	Boone
Schaefer, C. R.	Indianapolis	Marion
Schafer, William C.	Decatur	Marion
Schaible, E. L.	Gary	Lake
Schantz, Richard	Remington	Jasper-Newton
Schauwecker, Cleon M.	Milwaukee, Wis.	Putnam
Scheehter, John S.	Indianapolis	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier, E. W.	Indianapolis	Marion
Schell, Harry D.	Bloomington	Monroe
Schellhouse, Earl M.	Fort Wayne	Allen
Schenck, Foss	Logansport	Cass
Schenk, G. H.	Ridgeville	Randolph
Scherschel, John P.	Bedford	Lawrence
Scheurich, Virgil	Oxford	Benton
Schick, Martin F. (H)	Fort Wayne	Allen
Schiller, Herbert A.	South Bend	St. Joseph
Schirmer, Robert H.	Evansville	Vanderburgh
Schlegel, Edward H.	Fort Wayne	Allen
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Jacob	Hammond	Lake
Schlieker, A. G. (H)	East Chicago	Lake
Schlosser, H. C.	Elkhart	Elkhart
Schmidt, Loren F.	St. Joseph, Mo.	Marion
Schmiedicke, P. H.	W. Lafayette	Tippecanoe
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmoll, Robert J.	Fort Wayne	Allen
Schneider, Carl J.	Indianapolis	Marion
Schneider, C. P.	Evansville	Vanderburgh
Schoen, P. H. (H)	New Albany	Floyd
Schoolfield, Wm. E.	Orleans	Orange
Schott, Edward J.	Terre Haute	Vigo
Schriefer, E. E.	Cannelton	Perry
Schriefer, V. V.	Evansville	Vanderburgh
Schuchman, Gabriel	Indianapolis	Marion
Schuldt, T. S.	Pierecton	Kosciusko
Schuler, R. P.	Kokomo	Howard
Schulhof, M. G.	Muncie	Delaware-Blackford
Schulz, C. H.	Lagrange	Lagrange
Schulze, Hans A.	Indianapolis	Marion
Schulze, Wm.	Vincennes	Knox
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schutt, J. B.	Ligonier	Noble
Schwartz, David I.	Fort Wayne	Allen
Schwartz, W. D.	Portland	Jay
Schweitzer, Ada E.	Indianapolis	Marion
Scott, Charles C.	Indianapolis	Marion
Scott, Frank M.	South Bend	St. Joseph
Scott, G. D.	Sullivan	Sullivan
Scott, George E.	Hartford City	Delaware-Blackford
Scott, H. V.	Fort Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. W.	Indianapolis	Marion
Scott, R. F.	Kokomo	Howard
Scott, R. O.	Charlottesville	Hancock
Scott, S. L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, A. N.	Brownsburg	Hendricks
Scudder, J. A.	Edwardsport	Knox
Seal, Perry F.	Brookville	Marion
Seale, Joseph	Fairmount	Grant
Seaman, C. F.	Indianapolis	Marion
Sears, M. Maywood	Elkhart	Elkhart
Seaton, Albert	Indianapolis	Marion
Sedam, Herbert L.	Indianapolis	Marion
Segar, Louis H.	Indianapolis	Marion
Selby, K. E.	South Bend	St. Joseph
Selsam, Etta B.	Terre Haute	Vigo
Senese, T. J.	Gary	Lake
Sennett, C. M.	South Bend	St. Joseph
Sensenich, R. L.	South Bend	St. Joseph
Senseny, Herbert	Fort Wayne	Allen
Sessions, S. K. (H)	Anna, Ill.	Marion
Seward, G. W.	N. Manchester	Wabash
Sexson, Hiram	Indianapolis	Hancock
Seybert, J. D.	Kendallville	Noble
Seyler, Anna G.	Crown Point	Lake
Shacklett, H. B.	New Albany	Floyd
Shafer, J. W.	La Fayette	Tippecanoe
Shafer, Marion R.	Indianapolis	Marion
Shaffer, K. L.	Vincennes	Knox
Shallenberger, H. R.	Modoc	Randolph
Shanedling, Philip D.	Hammond	Lake
Shanklin, E. M.	Hammond	Lake
Shanklin, James	Ft. Steilacoom, Wash.	Lake
Shanklin, V. A.	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shanks, Roy E.	Rushville	Rush
Sharman, Edward J.	Madison	Jefferson
Sharp, John L.	Crawfordsville	Montgomery
Sharp, W. L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Shechan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Shellhouse, Michael	Gary	Lake
Shenk, E. M.	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sheridan, Joseph L.	Indianapolis	Marion
Sherman, Robert M.	Bluffton	Wells
Sherster, Harry	Indianapolis	Dubois
Shields, Harry A.	Washington	Daviess-Martin
Shields, Jack E.	Brownstown	Marion
Shields, Tom S.	Philadelphia, Pa.	Marion
Shinabery, Lawerence	Fort Wayne	Allen
Sholty, L. O.	La Fayette	Tippecanoe
Sholty, W. M.	La Fayette	Tippecanoe
Short, John	Fort Wayne	Allen
Shortridge, W. H.	Seymour	Jackson
Shortz, Gerald	Wollaston, Mass.	Noble
Shoup, H. B.	Greentown	Howard
Showalter, John	Waterloo	De Kalb
Shrader, Jack C.	Indianapolis	Marion
Shrock, E. E.	Amboy	Miami
Shuck, Wm. A.	Madison	Jefferson
Shugart, Joseph D.	Indianapolis	Marion
Shuler, L. L.	Indianapolis	Marion
Shullenberger, W. A.	Indianapolis	Marion
Shulruff, H. I.	East Chicago	Lake
Shultz, H. M.	Logansport	Cass
Sicks, O. W.	Indianapolis	Marion
Siebenmorgen, Louis	Terre Haute	Vigo
Siekerman, C. W.	Indianapolis	Marion
Siekierski, J. M.	Griffith	Lake
Siersdorfer, T. N.	Indianapolis	Marion
Siewert, O. L.	Aurora, Ill.	Cass
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, Wm. B.	Columbus	Bartholomew-Brown
Silbert, David B.	Shelbyville	Shelby
Silverman, Norman M.	Riley	Vigo
Silvers, J. C.	Muncie	Delaware-Blackford
Silvers, J. M.	Muncie	Delaware-Blackford
Silvian, Harry	Whiting	Lake
Simmons, Frederick H.	Indianapolis	Marion
Simmons, L. H.	Goshen	Elkhart
Simon, A. R.	La Porte	La Porte
Simons, J. S. (H)	Lyons	Greene
Simpson, Morrell E.	St. Petersburg, Fla.	Lawrence
Sims, J. Lawrence	Indianapolis	Marion
Sims, S. B. (H)	Frankfort	Clinton
Singer, E. C.	Fort Wayne	Allen
Sink, Frank G.	Remington	Jasper-Newton
Sirlin, E. M.	Mishawaka	St. Joseph
Sisson, Helen M.	Pendleton	Madison
Skeen, E. D.	Gary	Lake
Skillern, P. G.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Skrentny, Stanley	Hammond	Lake
Slabaugh, J. S.	Nappanee	Elkhart
Slabaugh, Lotus M.	Nappanee	Elkhart
Slaughter, Howard C.	Evansville	Vanderburgh
Slegelmilch, Lorin	Long Beach, Calif.	Wabash
Slick, C. R.	Lynn	Randolph
Sloan, H. P.	New Albany	Floyd
Sloan, Willard K.	Madison	Jefferson
Slominski, H. H.	South Bend	St. Joseph
Sloss, I. H.	Terre Haute	Vigo
Sluss, David H.	Indianapolis	Marion
Sluss, John W. (H)	Indianapolis	Marion
Small, E. F.	Vincennes	Knox
Smallwood, R. B.	Bedford	Lawrence
Smelser, H. W.	Connersville	Fayette-Franklin
Smiley, J. H.	Indianapolis	Marion
Smith, B. J.	Kingman	Fountain-Warren
Smith, David J.	Indianapolis	Marion
Smith, D. L.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion

Name	City	County
Smith, Francis C.	Indianapolis	Marion
Smith, G. A.	New Haven	Allen
Smith, H. Brooks	Bluffton	Wells
Smith, H. N.	Brookville	Fayette-Franklin
Smith, H. S.	Bloomington	Lake
Smith, James M.	Indianapolis	Marion
Smith, James S.	Muncie	Delaware-Blackford
Smith, John H.	Atlanta, Ga.	Monroe
Smith, Joseph S.	Plainfield	Hendricks
Smith, L. C.	La Fayette	Tippecanoe
Smith, L. W.	Warren	Huntington
Smith, Lawson F.	La Veta, Colo.	Marion
Smith, Lester A.	Indianapolis	Marion
Smith, Louis D.	Chicago, Ill.	Lake
Smith, Marsh H.	W. Lafayette	Tippecanoe
Smith, Paul E.	Ellettsville	Tipton
Smith, R. A.	New Castle	Henry
Smith, R. D. (H)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Roy L.	Indianapolis	Marion
Smith, T. J.	Whiting	Lake
Smith, W. E.	Decatur	Adams
Smith, Wilbur F.	Indianapolis	Marion
Smithson, Robert A.	Indianapolis	Vanderburgh
Smoot, E. Brayton	Washington	Daviess-Martin
Smoots, S. A.	Terre Haute	Vigo
Smullen, Willard C.	Rushville	Rush
Sneary, K. D.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snodgrass, Milo R.	Michigan City	La Porte
Snyder, E. R.	Troy	Perry
Snyder, Morris C.	Richmond	Wayne-Union
Solomon, R. A.	Indianapolis	Marion
Somers, G. H.	Fort Wayne	Allen
Souder, Bonnell M.	Auburn	De Kalb
Sourwine, C. C.	Brazil	Clay
Souter, Martha C.	Indianapolis	Marion
Southard, C. B.	Noblesville	Hamilton
Sovine, Joe W.	Indianapolis	Marion
Spahr, D. E.	Portland	Jay
Spahr, John F.	Indianapolis	Marion
Spalding, J. J.	Indianapolis	Marion
Spalding, W. L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Sparks, A. J.	Fort Wayne	Allen
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spaulding, Earl	New Albany	Floyd
Spears, John K.	Paoli	Orange
Speheger, Benjamin A.	Bedford	Lawrence
Spencer, Frederic	Vincennes	Knox
Spenner, R. W.	South Bend	St. Joseph
Spieth, Wm. H.	Lebanon	Boone
Spigler, James	Terre Haute	Vigo
Spindler, Robert D.	New Castle	Henry
Spink, Urbana	Indianapolis	Marion
Spinning, Alva (H)	Michigan City	Fountain-Warren
Spivey, R. J.	Indianapolis	Marion
Spolyar, L. W.	Indianapolis	Marion
Springstun, C. E.	Tennyson	Warrick
Springstun, C. L.	Chrisney	Spencer
Springstun, George	Oaktown	Knox
Springstun, W. R.	Evansville	Vanderburgh
Spurgeon, O. E.	Muncie	Delaware-Blackford
Sputh, Carl B., Sr.	Indianapolis	Marion
Sputh, Carl B., Jr.	Indianapolis	Marion
Stadler, Harold E.	Indianapolis	Marion
Stafford, J. C.	Plainfield	Hendricks
Stafford, W. C.	Plainfield	Hendricks
Stahl, Edward	La Fayette	Tippecanoe
Stalker, James B.	Indianapolis	Marion
Stamper, J. H.	Anderson	Henry
Stamper, L. Allen	Richmond	Wayne-Union
Stangle, W. J.	Camby	Marion
Stanley, J. S.	Indianapolis	Lake
Stanton, J. J.	Logansport	Cass
Stauffer, George E.	Indianapolis	Marion
Stauffer, Walter A.	Elkhart	Elkhart
Stayton, C. A.	Indianapolis	Marion
Stayton, Chester A., Jr.	Indianapolis	Marion
Steey, Peter	Whiting	Lake
Steele, Brandt F.	Indianapolis	Marion
Steele, D. J.	Greencastle	Putnam
Steele, E. B.	Crown Point	Lake
Steele, Paul W.	Indianapolis	Marion
Steffen, A. J.	Wabash	Wabash
Steffen, J. T.	Wabash	Wabash
Steinkamp, E. F.	Huntingburg	Dubois
Steinman, H. E.	Monroeville	Allen
Stellner, Howard A.	Fort Wayne	Madison
Stemm, W. H. (H)	North Vernon	Jennings
Stephens, K. H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stephens, R. Clarence (H)	Plymouth	Marshall
Stephenson, L. E.	Michigan City	La Porte
Stern, Nathan	Indianapolis	Marion
Stern, S. L.	Hammond	Lake
Stevens, S. L.	Indianapolis	Marion
Stewart, Chas. S.	Auburn	De Kalb
Stewart, J. H.	Durham, N. C.	Grant
Stewart, Milton B.	Logansport	Cass
Stewart, O. H.	Aurora	Dearborn-Ohio
Stewart, W. E.	Terre Haute	Vigo
Stier, Paul L.	Fort Wayne	Allen
Stimson, Harry R.	Gary	Lake
Stinson, A. E.	Rochester	Fulton
Stinson, Dean K.	Rochester	Fulton
Stirling, E. H.	Indianapolis	Marion
Stiver, Daniel	South Bend	St. Joseph
Stocking, B. W.	Muncie	Delaware-Blackford
Stoeffler, Walter	Indianapolis	Marion
Stoelting, V. K.	Iowa City, Ia.	Randolph
Stoen, H. J.	La Fayette	Tippecanoe
Stoler, A. E.	Fort Wayne	Allen
Stone, A. T.	Indianapolis	Marion
Stone, Charles E.	Bedford	Lawrence
Stone, David F.	Indianapolis	Marion
Stoops, Jean T.	Wabash	Wabash
Storer, Wm. R.	Hobart	Lake
Storey, D. E.	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey	Huntingburg	Dubois
Stork, Urban	Evansville	Vanderburgh
Storms, Roy B.	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stouder, C. E.	Gosport	Owen
Stout, R. B.	Elkhart	Elkhart
Stout, Walter M.	New Castle	Henry
Stover, W. C.	Boonville	Warrick
Stoycoff, C. M.	Gary	Lake
Strange, J. W.	Loogootee	Daviess-Martin
Strange, Martin B.	New Albany	Floyd
Straughn, Walter L.	Crawfordsville	Montgomery
Straus, David C.	Michigan City	La Porte
Strayer, J. W.	La Fayette	Tippecanoe
Streck, F. A.	Lawrenceburg	Dearborn-Ohio
Streepey, J. I.	New Albany	Floyd
Streib, Homer F.	Portland	Jay
Strickland, Karl S.	Owensville	Gibson
Strong, Daniel S.	Terre Haute	Vigo
Stroup, Tyler J.	Indianapolis	Marion
Stuckman, E. D.	New Paris	Elkhart
Stucky, Elsworth	Indianapolis	Marion
Studebaker, Lloyd R.	New Paris	Elkhart
Study, Joseph N. (H)	Cambridge City	Wayne-Union
Stultz, Q. F.	Ligonier	Noble
Stygall, J. H.	Indianapolis	Marion
Sudranski, Herbert F.	Indianapolis	Marion
Sullenger, A. A.	Indianapolis	Marion
Sullivan, John M.	Terre Haute	Vigo
Sullivan, T. L.	Indianapolis	Marion
Susott, Kathryn C.	Tokyo, Japan	Warrick
Sutter, Charles C.	Evansville	Vanderburgh
Sutton, Wm. E.	Indianapolis	Johnson
Suverkrup, Lotta A.	Columbus	Bartholomew-Brown
Swan, John R.	Indianapolis	Marion
Swan, Richard Carl	Anderson	Madison
Swank, L. Forrest	Elkhart	Elkhart
Swanson, John	St. Petersburg, Fla.	Allen
Swarts, Willard W.	Three Rivers, Mich.	De Kalb
Swayne, J. F.	Indianapolis	Marion
Sweet, Howard E.	Richmond	Wayne-Union
Swezey, H. N.	La Fayette	Tippecanoe
Swihart, L. F.	Elkhart	Elkhart
Switzer, Robert E.	Cromwell	Noble
Szabo, S. A.	East Chicago	Lake
Take, J. F.	French Lick	Dubois
Talbott, Dan E.	Indianapolis	Marion
Tallman, H. H.	Culver	Marshall
Tanner, Henry S.	Indianapolis	Marion
Tate, W. W.	Thayer	Jasper-Newton
Tavenner, Fred	Gas City	Grant
Taylor, C. C.	Indianapolis	Marion
Taylor, D. E.	Velpen	Pike
Taylor, E. C.	Upland	Grant
Taylor, Eugene C.	Evansville	Vanderburgh
Taylor, F. W.	Indianapolis	Marion
Taylor, J. E.	Leopold	Perry
Taylor, L. S.	Elberfeld	Warrick
Taylor, W. H.	Ambia	Benton
Taylor, W. M.	Crawfordsville	Montgomery
Taylor, W. R.	Richmond	Wayne-Union
Teaford, S. F.	Paoli	Orange
Teague, Frank	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Tecgarden, J. A., Jr.	East Chicago	Lake
Teegarden, J. A., Sr.	East Chicago	Lake
Teeter, E. J.	Indianapolis	Marion
Teixler, V. A.	Indianapolis	Marion
Templin, D. B.	Gary	Lake
Tennant, David L.	Fort Wayne	Allen
Tennant, L. W.	Fort Wayne	Whitley
Tennis, George	Greencastle	Putnam
Teplinsky, L. Louis	Address Unknown	Lake
Terflinger, F. W.	Logansport	Cass
Terrill, R. W.	Fort Wayne	Allen
Terry, C. C.	South Bend	St. Joseph
Teters, Melvin	Middlebury	Elkhart
Tether, Joseph E., Jr.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, H. K., Jr.	Indianapolis	Marion
Thayer, B. W.	North Vernon	Jennings
Thayer, J. O.	Noblesville	Marion
Thimlar, J. Wiley	Fort Wayne	Allen
Thom, Jay W.	Camp Campbell, Ky.	Owen-Monroe
Thom, Julia S.	Spencer	Owen-Monroe
Thomas, C. B.	Plainfield	Hendricks
Thomas, C. E.	Leesburg	Kosciusko
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion
Thomas, G. A.	La Fayette	Tippecanoe
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris C.	Dayton, Ohio	Marion
Thomas, Morris E.	Indianapolis	Marion
Thomas, Ray H.	South Bend	St. Joseph
Thompson, A. A.	Tyner	Marshall
Thompson, Chas. F.	Indianapolis	Marion
Thompson, Holland	Fort Wayne	Marion
Thompson, J. V.	Indianapolis	Marion
Thompson, John M.	Bremen	Marshall
Thompson, Lewis	New Harmony	Posey
Thompson, N. H.	Wabash	Wabash
Thompson, Paul V.	Indianapolis	Marion
Thompson, W. A.	Liberty	Wayne-Union
*Thornburg, Kenneth	Indianapolis	Marion
Thorne, C. E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter	Fort Wayne	Allen
Thrasher, John R.	Indianapolis	Marion
Thurston, A. L.	Indianapolis	Marion

Name	City	County
Thurston, H. F.	Indianapolis	Marion
Thurston, H. S.	Indianapolis	Marion
Tiley, George	Greenwood	Johnson
Tindal, E. F. (H)	Muncie	Delaware-Blackford
Tindall, Paul R.	Shelbyville	Shelby
Tindall, Wm. R.	Shelbyville	Shelby
Tinney, W. E.	Indianapolis	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, W. B.	Indianapolis	Marion
Tipton, Wm. R.	Greencastle	Putnam
Tischer, E. P.	Indianapolis	Marion
Titus, Charles	Wilkinson	Hancock
Titus, Philip S.	Fort Wayne	Allen
Todd, D. D.	Elkhart	Elkhart
Tomak, M. E.	Linton	Greene
Tomlinson, C. H. (H)	Cicero	Hamilton
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, M. C.	Terre Haute	Vigo
Torrella, J. A.	Indianapolis	Marion
Totten, E. C.	Madison	Jefferson
Tower, Thomas K.	Campbellsburg	Washington
Tracy, J. Ross	Anderson	Madison
Tranter, W. F.	Sharpsville	Tipton
Traver, P. C.	South Bend	St. Joseph
Travis, J. C., Jr.	Indianapolis	Marion
Tremain, M. A.	Adams	Decatur
Tremor, V. F.	Indianapolis	Marion
Treon, James F.	Aurora	Dearborn-Ohio
Tripp, H. D.	Plymouth	Marshall
Trout, C. J.	Lafayette	Tippecanoe
Troutwine, William R.	Crown Point	Lake
Trusler, H. M.	Indianapolis	Marion
Tubbs, George R.	La Fayette	Tippecanoe
Tucker, O. A.	Daleville	Delaware-Blackford
Tucker, Warren S.	Indianapolis	Marion
Tully, J. A.	New Castle	Henry
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson
Turner, H. B.	Bloomfield	Greene
Turner, Oscar A.	Madison	Jefferson
Turner, Robert	Muncie	Delaware-Blackford
Tweedall, D. C.	Evansville	Vanderburgh
Tweedall, D. G.	Evansville	Vanderburgh
Tyler, F. T.	New Albany	Floyd
Tyner, Harlan H.	Clayton	Hendricks
Tyrrell, Thomas C.	Calumet City, Ill.	Lake
Uhrich, John H.	Monroeville	Allen
Underwood, G. B.	Evansville	Vanderburgh
Unger, L. L.	Farmland	Randolph
Urschel, Dan L.	Mentone	Kosciusko
Utterback, Arnold	Terre Haute	Vigo
Van Arsdall, C. R.	Terre Haute	Vigo
Van Bokkelen, Robert	Mooresville	Morgan
VanBuskirk, E. L.	La Fayette	Tippecanoe
Van Buskirk, E. M.	Fort Wayne	Allen
Vance, Wm. C.	Richmond	Wayne-Union
Vandemark, Walter E.	Indianapolis	Marion
Vanderbogart, H. E.	Goshen	Elkhart
Vandevert, Arthur	Sellersburg	Clark
Vandivier, H. R.	Terre Haute	Vigo
Vandivier, R. M.	Indianapolis	Marion
Van Dorf, Nathaniel	Chicago, Ill.	Lake
Van Dorn, Myron J.	Marion	Grant
Van Kirk, George H.	Kentland	Jasper-Newton
Van Kirk, J. A.	Frankfort	Clinton
Van Meter, C. Powell	Indianapolis	Marion
Van Ness, William C.	Summitville	Madison
Van Nest, W. A.	New Smyrna Beach, Fla.	De Kalb
Van Nuys, John D.	Indianapolis	Marion
Van Nuys, W. C.	New Castle	Henry
Van Osdol, H. A.	Indianapolis	Marion
Van Rie, L. P.	Mishawaka	St. Joseph
Van Sandt, F. A.	Bloomfield	Greene
Van Sandt, J. W.	Carbon	Clay
Van Vactor, Helen D.	Indianapolis	Marion
Van Winkle, Arthur J.	Valparaiso	Porter
Varble, Wm. M.	Jeffersonville	Clark
Veach, Lester W.	Bainbridge	Putnam
Veach, Richard L.	Bainbridge	Putnam
Veazey, Wm. (H)	Avilla	Noble
Velkoff, Metodi	Warren, Ohio	Allen
Venable, George L.	N. Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware-Blackford
Verplank, G. L.	Gary	Lake
Vetter, K. W.	Florida	Elkhart
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, P. C. F.	Valparaiso	Porter
Viney, Charles L.	Logansport	Cass
Visher, John W.	Evansville	Vanderburgh
Vlaskamp, Elaine	Muncie	Delaware-Blackford
Vogel, L. John	Mt. Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Voisinet, R. A.	Union City	Randolph
Vollrath, V. J.	Indianapolis	Shelby
Vore, Hugh A.	East Chicago	Lake
Vore, L. W.	Plymouth	Marshall
Voyles, C. F.	Indianapolis	Marion
Voyles, Glenn Q.	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd
Vracin, Daniel	Griffith	Lake
Vye, James P.	Gary	Lake
Wach, Joseph J.	Hammond	Lake
Wade, A. A.	Howe	Lagrange
Wadsworth, H. C.	Washington	Daviess-Martin
Wagner, S. C.	Elkhart	Elkhart
Wagoner, G. W.	Delphi	Carroll
Wagoner, Robert H.	Colburn	Tippecanoe
Waldo, J. Thayer	Indianapolis	Marion
Wales, E. De Wolfe	Indianapolis	Marion
Walker, Floyd B.	Fort Wayne	Allen
Walker, F. C.	Indianapolis	Marion
Walker, J. L.	La Fontaine	Wabash
Walker, James S.	Baltimore, Md.	Marion
Walker, Robert K.	Indianapolis	Marion
Walkinshaw, Wm. (H)	Stillwell	La Porte
Wall, Joseph A.	Wabash	Wabash
Wallace, E. R.	Aurora	Dearborn-Ohio
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Wallace, J. C.	Fort Wayne	Allen
Waller, John I.	Chicago, Ill.	Henry
Waller, W. F.	Angola	Steuben
Walsh, Edmund N.	Temple, Texas	Lake
Walsh, T. P.	Garrett	De Kalb
Walterhouse, H. K.	Ladoga	Montgomery
Walters, Charles E.	Indianapolis	Marion
Walters, L. O.	Muncie	Delaware-Blackford
Wanninger, Horace	Richmond	Wayne-Union
Ward, H. H.	Coalmont	Clay
Ward, J. W.	Mishawaka	St. Joseph
Ward, Wesley C.	Indianapolis	Marion
Ware, J. R.	Huntington	Huntington
Warfel, F. C.	Indianapolis	Marion
Warman, A. P.	Indianapolis	Marion
Warn, William J.	Milan	Ripley
Warne, G. H.	Tipton	Tipton
Warren, Carroll B.	Marion	Marion
Warren, Frank R.	Michigan City	La Porte
Warren, John C.	Vincennes	Knox
Warriner, James B.	Indianapolis	Marion
Warvel, J. H.	Indianapolis	Marion
Warvel, J. L. (H)	N. Manchester	Wabash
Washburn, Richard N.	Rensselaer	Jasper-Newton
Washburn, W. W.	La Fayette	Tippecanoe
Wasley, Malcolm T.	Antioch, Calif.	Delaware-Blackford
Watson, Herman L.	Evansville	Vanderburgh
Watts, A. A.	Gary	Lake
Waymire, E. S.	Indianapolis	Marion
Weaver, T. M.	Brazil	Clay
Weaver, Wm. W.	New Albany	Floyd
Weber, Edgar H.	Evansville	Vanderburgh
Weber, Joseph G. S.	Terre Haute	Vigo
Webster, R. K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone
Weeks, P. H.	Michigan City	La Porte
Weems, M. P.	Jeffersonville	Clark
Wegner, W. G.	South Bend	St. Joseph
Wehrman, J. O.	Indianapolis	Marion
Weigand, C. G.	Indianapolis	Marion
Well, H. J.	Indianapolis	Marion
Weinberg, Samuel	Marion	Grant
Weinstein, E. B.	Richmond	Wayne-Union
Weinstein, J. H.	Terre Haute	Vigo
Weinstein, Louis	Marion	Grant
Weirich, Charles	Butler	De Kalb
Weis, William D.	Crown Point	Lake
Weiskopf, Henry S.	Gary	Lake
Weiss, Eugene	South Bend	St. Joseph
Weiss, H. G.	Evansville	Vanderburgh
Weiss, Jason	Indianapolis	Marion
Weissman, Irving	Madison, Wis.	Allen
Welborn, J. Y.	Evansville	Vanderburgh
Welborn, Mell B.	Evansville	Vanderburgh
Weller, Charles A.	Indianapolis	Marion
Welty, S. G.	Fort Wayne	Allen
Werry, L. E.	Hartford City	Delaware-Blackford
Wesson, Thomas W.	Evansville	Vanderburgh
West, Joseph L.	Indianapolis	Marion
Westfall, B. Kemper	Indianapolis	Marion
Westfall, John B.	Indianapolis	Marion
Westhafer, E. K.	New Castle	Henry
Weyerbacher, A. F.	Indianapolis	Marion
Whallon, Arthur J.	Richmond	Wayne-Union
Wharton, R. O.	Gary	Lake
Wheeler, J. T. (H)	Indianapolis	Marion
Whipps, Charles E.	Carlisle	Sullivan
Whisler, F. M.	Wabash	Wabash
White, C. M.	Clinton	Parke-Vermillion
White, C. S.	Rosedale	Parke-Vermillion
White, Claude H.	Mooresville	Morgan
White, Donald J.	Indianapolis	Marion
White, Harvey E.	Farmland	Randolph
White, I. D.	Clinton	Parke-Vermillion
White, James V.	Terre Haute	Vigo
White, W. J.	Gary	Lake
Whitehead, John M.	Indianapolis	Marion
Whitlatch, Arthur	Milan	Ripley
Whitlatch, I. A.	Milan	Ripley
Whitlock, Francis C.	Indianapolis	Marion
Whitlock, Merle E.	Mishawaka	St. Joseph
Whitsitt, S. A.	Madison	Jefferson
Whitten, Kathryn	Los Angeles, Calif.	Allen
Wickens, Mary	Richmond	Wayne-Union
Wicks, O. C.	Gary	Lake
Wiedemann, F. E.	Terre Haute	Vigo
Wiggins, D. S.	New Castle	Henry
Wiggins, George	New Castle	Henry
Wilber, H. R.	Jeffersonville	Clark
Wilcox, R. F.	La Porte	La Porte
Wilder, G. B.	Anderson	Madison
Wildman, R. E.	Peru	Miami
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelmus, C. K.	Newburgh	Warrick
Wilhelmus, Charles M.	Newburgh	Warrick
Wilhelmus, Wm. M.	St. Wendell	Vanderburgh
Wilkens, I. W.	Indianapolis	Marion
Wilkins, R. W.	Fort Wayne	Allen
Wilkinson, Roger L.	Anderson	Madison
Willan, H. R.	Martinsville	Morgan
Willett, I. H.	Fort Wayne	Allen
Williams, A. H.	Fort Wayne	Allen
Williams, Berniece	New Haven	Allen
Williams, Charles D.	Indianapolis	Marion
Williams, C. L.	Indianapolis	Cass
Williams, Everett W.	Columbus	Bartholomew-Brown

Name	City	County
Williams, F. M., Jr.	Pendleton	Madison
Williams, F. P.	Huntingburg	Dubois
Williams, Frederic N.	Mt. Vernon	Posey
Williams, H. O.	Kendallville	Noble
Williams, Howard S.	Indianapolis	Marion
Williams, John H.	Muncie	Delaware-Blackford
Williams, Paul D.	Martinsville	Morgan
Williams, R. H.	Baltimore, Md.	Madison
Willis, Charles F.	Evansville	Vanderburgh
Willis, Joseph H.	Evansville	Vanderburgh
Willison, George	Evansville	Vanderburgh
Wills, Benjamin F.	Union City	Randolph
Willson, C. L.	Anderson	Madison
Wilmore, Ralph C.	Indianapolis	Marion
Wilson, F. M.	Kokomo	Howard
Wilson, Fred	Terre Haute	Vigo
Wilson, Guy	Bicknell	Knox
Wilson, J. L.	South Bend	St. Joseph
Wilson, J. P. (H)	Scottsburg	Scott
Wilson, J. R.	Terre Haute	Vigo
Wilson, L. A.	Michigan City	La Porte
Wilson, Leslie	Fort Wayne	Allen
Wilson, O. E.	Elkbart	Elkhart
Wilson, O. R.	Indianapolis	Marion
Wilson, Paul	Boonville	Warrick
Wilson, P. H.	Logansport	Cass
Wilson, R. C.	Franklin	Johnson
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Ralph	Shirley	Henry
Wilson, Roland B.	Fort Wayne	Allen
Wilson, T. L.	Bloomington	Owen-Monroe
Wiltshire, James W.	Bloomington	Owen-Monroe
Wimmer, G. G.	Huntington	Huntington
Wimmer, Robert N.	Gary	Lake
Winebrenner, J. D.	Bremen, Germany	Bartholomew-Brown
Winstandley, W. C.	New Albany	Floyd
Winter, Donald K.	Logansport	Cass
Winters, Matthew	Indianapolis	Marion
Wisch, L. J.	Whiting	Lake
Wise, Charles	Camden	Carroll
Wise, Wm.	Indianapolis	Marion
Wisehart, Wm. (H)	Colfax	Clinton
Wiseheart, Oscar H.	North Salem	Hendricks
Wiseheart, Robert	Lebanon	Boone
Wiseman, V. Earle	Greencastle	Putnam
Wisener, G. H.	Richmond	Wayne-Union
Wishard, F. B.	Anderson	Madison
Wishard, Wm. N., Jr.	Indianapolis	Marion
Wishart, S. W.	Evansville	Vanderburgh
Wissman, William L.	Columbus	Bartholomew
Wohlfeld, J. B.	Bedford	Lawrence
Wolfram, Don J.	Indianapolis	Marion
Woner, John W.	Linton	Greene
Wood, Amelia T.	Muncie	Delaware-Blackford
Wood, Charles	Westport	Decatur
Wood, Donald E.	Indianapolis	Marion
Wood, E. U.	Columbus	Bartholomew-Brown
Wood, George	Indianapolis	Marion
Wood, O. L.	Brazil	Clay
Wood, R. W.	Oakland City	Gibson
Wood, W. B.	Oakland City	Gibson
Wood, W. H.	Evansville	Vanderburgh
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodcock, C. E.	Greenwood	Johnson
Woods, A. L.	Poseyville	Posey
Woods, H. C.	Markle	Huntington
Woods, James R.	Greenfield	Hancock
Woods, Wm. V.	Indianapolis	Marion
Wooldridge, Omer	Kokomo	Howard
Woolery, R. H.	Indianapolis	Marion
Work, Bruce A.	Frankfort	Clinton
Work, James A.	Elkhart	Elkhart
Workman, W. S. (H)	Indianapolis	Orange
Worley, A. C.	Fort Wayne	Allen
Worley, Henry Lee	Henryville	Clark
Worley, J. P.	Indianapolis	Marion
Worth, C. W.	Milroy	Rush
Wray, C. M.	La Fayette	Tippecanoe
Wright, Cecil S.	Anderson	Madison
Wright, E. D.	Seymour	Jackson
Wright, J. William	Indianapolis	Marion
Wright, W. C.	Fort Wayne	Allen
Wright, W. W.	New Castle	Henry
Wurster, H. C.	Mishawaka	St. Joseph
Wyatt, Fred H.	Evansville	Vanderburgh
Wyatt, James L., II	Fort Wayne	Allen
Wyatt, James L. III	Fort Wayne	Allen
Wybourn, R. C.	Columbia City	Wells
Wyeth, Charles (H)	Terre Haute	Vigo
Wygant, M. D.	Mishawaka	St. Joseph
Wyland, B. J.	Mishawaka	St. Joseph
Wynn, J. F.	Evansville	Vanderburgh
Wynne, R. E.	Bedford	Lawrence
Wyttenbach, Frederick	Indianapolis	Marion
Wyttenbach, John E.	Indianapolis	Marion
Yarling, J. E. (H)	Peru	Miami
Yarrington, C. W.	Gary	Lake
Yeck, C. W.	Evansville	Vanderburgh
Yegerlehner, Roscoe	Kentland	Jasper-Newton
Yencer, M. W.	Richmond	Wayne-Union
Yocum, Boaz (H)	Coal City	Owen-Monroe
Yocum, P. S.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, Albert C.	Goshen	Elkhart
Yoder, D. D.	Columbus	Bartholomew-Brown
Yoder, Jonathan G.	Goshen	Elkhart
Yoder, Richard P.	Bluffton	Wells
York, Arthur F.	Anderson	Madison
Youman, Thomas	W. Lafayette	Tippecanoe
Young, E. M.	Sheridan	Hamilton
Young, G. M.	Gary	Lake
Young, G. S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, Ralph H.	Goshen	Elkhart
Young, Robert	Marion	Grant
Young, S. J. (H)	Kendallville	Noble
Young, W. C.	Washington, D. C.	Marion
Yung, J. Rudolph	Terre Haute	Vigo
Yunker, P. E.	Evansville	Vanderburgh
Zallen, S. G.	East Chicago	Lake
Zaring, B. K.	Columbus	Bartholomew-Brown
Zehr, Noah	Fort Wayne	Allen
Zerfas, L. G.	Merom	Sullivan
Zierer, R. O.	Anderson	Madison
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, R. G.	Berne	Adams
Zink, Robert O.	Veray	Switzerland
Zivich, J. M.	East Chicago	Lake
Zweig, E. S.	Fort Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold	Decatur	Adams
Zwickel, R. E.	Newburgh	Warrick

ROSTER OF MEMBERS BY COUNTIES

(As of November 30, 1946)

Physicians are listed in the counties in which they reside

ADAMS COUNTY

Habegger, Myron L.....Berne
Dester, H. E.....Berne
Jones, D. D.....Berne
Lehman, Robert J.....Berne
Reusser, Amos (H).....Berne
Zimmerman, Russell G.....Berne
Burk, James M.....Decatur
Carroll, John C.....Decatur
Duke, Benjamin E.....Decatur
Kohne, Gerald J.....Decatur
Parrish, Richard K.....Decatur
Rayl, Claudius C.....Decatur
Reppert, Roland L.....Decatur
Schofer, William C.....Decatur
Smith, Waldo E.....Decatur
Zwick, Harold F.....Decatur
Hinchman, Clarence P.....Geneva
Eicher, Palmer.....605 N. W. 10th St., Oklahoma City, Okla.

ALLEN COUNTY

Fort Wayne

Adams, John R.....621 W. Berry St., (2)
Aiken, Nevin E.....935 Lincoln Tower (2)
Aldrich, Harry.....2710 S. Broadway (8)
Bailey, Paul P....206 Wayne Pharmacal Bldg. (2)
Baltes, Joseph H.....721 Broadway (2)
Bartholomew, Alfred C...405 Dime Bank Bldg. (2)
Baumgartner, J. C..515 Wayne Pharmacal Bldg. (2)
Beierlein, Karl M..334 Wayne Pharmacal Bldg. (2)
Benninghoff, D. R..208 Wayne Pharmacal Bldg. (2)
Berghoff, Raymond J.....306 E. Jefferson St. (2)
Bickel, John E.....2615 S. Lafayette St. (2)
Blosser, Howard V.....309 W. Main St. (2)
Boerger, Victor L.....734 W. Washington St.
Bolman, Ralph M..702 Wayne Pharmacal Bldg. (2)
Borders, Theodore R....1145 S. Lafayette St. (2)
Bowers, G. T.....307 E. Jefferson (2)
Bowers, Jesse W.....418 Gettle Bldg.
Brosius, Robert H.....1603 Wells St. (7)
Bruggeman, H. O..604 Wayne Pharmacal Bldg. (2)
Buckner, Doster.....421 W. Wayne St. (2)
Bulson, Eugene L..102 Wayne Pharmacal Bldg. (2)
Burns, Elizabeth V.....352 W. Wayne St. (2)
Calvin, Jessie C. (H).....312 W. Wayne St. (2)
Cameron, Don F...702 Wayne Pharmacal Bldg. (2)
Carey, Willis W. (H).....2525 S. Calhoun (5)
Carlo, Ernest R.....2902 Fairfield Ave. (6)
Cartwright, E. L..230 Wayne Pharmacal Bldg. (2)
Catlett, Marshall B.....232 W. Wayne St. (2)
Chambers, Alan R.....602 W. Wayne St. (2)
Clark, William R.....305 Cal Wayne Bldg. (2)
Conley, John E.....620 W. Berry St. (2)
Cooney, Charles J.....527 W. Berry St. (2)
Cornell, Beaumont.....435 Lincoln Bank Tower
Culp, John E.....2902 Fairfield Ave. (6)
Dancer, C. R.....228 Wayne Pharmacal Bldg. (2)
Ditton, Irwin W.....1214 E. Wayne St. (4)
Draper, Merlin H.....Irene Byron Sanitarium
Duemling, Arnold H.....2902 Fairfield Ave. (2)

ALLEN COUNTY—(Cont.)

Fort Wayne

Duemling, W. W.....2902 Fairfield Ave. (2)
Dunstone, H. C...502 Wayne Pharmacal Bldg. (2)
Eberly, Karl C....310 Wayne Pharmacal Bldg. (2)
Edlaviteh, Baruch M.....716 Roekhill St. (2)
Elston, Lynn W...622 Wayne Pharmacal Bldg. (2)
Elston, Ralph W..622 Wayne Pharmacal Bldg. (2)
English, Calvin H. (H).....2509 Webster St. (6)
Estlick, R. E.....629 Wayne Pharmacal Bldg. (2)
Ferguson, Arthur N.....2902 Fairfield Ave. (6)
Fichman, Abraham M.....323 W. Berry St. (2)
Foy, Hayward W.....1747 Wells St. (7)
Garton, Harry W.....3012 Shawnee Dr. (6)
Gerding, William J.....2714 S. Anthony Blvd.
Gessler, William F.....2902 Fairfield (6)
Gladstone, Naf H.....335 W. Berry St. (2)
Glock, Homer E...324 Wayne Pharmacal Bldg. (2)
Glock, Maurice E.....312 W. Wayne St. (2)
Glock, Wayne R.....312 W. Wayne St. (2)
Gould, Lyman K.....3415 S. Fairfield Ave. (6)
Graf, John E.....801 E. State Blvd.
Haffner, Herman G.....202 E. Jefferson St. (2)
Hane, Richard L...418 Wayne Pharmacal Bldg. (2)
Hardesty, Kile C.....2109 Broadway
Harshman, L. P.....2704 N. Clinton (3)
Harvey, Harry C.....1202 East State St. (3)
Hasewinkle, August M.....1129 E. State St. (3)
Hattendorf, A. P..707 Wayne Pharmacal Bldg. (2)
Hoffman, Arthur F.....Fort Wayne
Hoffman, S. P., Jr..424 Wayne Pharmacal Bldg. (2)
Hoffman, S. P....424 Wayne Pharmacal Bldg. (2)
Holsinger, Robert E.....832 E. Creighton (5)
Kidder, Orva T.....Irene Byron Sanitarium
Kruse, Edward H.....705 Lincoln Tower (2)
Kruse, Walter E...512 Wayne Pharmacal Bldg. (2)
Ladig, Donald S.....337 E. Berry St. (2)
Lenk, George G.....2007 Maumee Ave. (4)
Lloyd, Robert P.....1225 Crescent Avenue
Lohman, M. R....618 Wayne Pharmacal Bldg. (2)
Lohman, R. M.....618 Wayne Pharmacal Bldg. (2)
Macbeth, Albert H. (H)...1130 S. Fafayette (2)
McArdle, Edward G.....2201 S. Calhoun St. (5)
McCabe, Theodore E.....1822 S. Calhoun St. (5)
McCoy, Roy R.....3701 S. Harrison St. (6)
McDowell, George A.....426 Gettle Bldg. (2)
McFadden, James E..St. Elizabeth Hosp., Lafayette
McKeeman, Donald H.....633 W. Wayne St. (2)
McKeeman, L. S...302 Wayne Pharmacal Bldg. (2)
Mendenhall, Edgar.208 Wayne Pharmacal Bldg. (2)
Mercer, Sam R....710 Wayne Pharmacal Bldg. (2)
Meyer, Herman A.....1030 W. Wayne St. (2)
Michaelis, Stephen C.....2154 Fairfield Ave. (6)
Miller, Carl G.....320 W. Wayne St. (2)
Miller, H. Paul.....1801 S. Lafayette (5)
Miller, Mahlon F..334 Wayne Pharmacal Bldg. (2)
Miller, Orval J.....324 W. Berry St. (2)
Miller, Richard H.....511 W. Wayne St. (2)
Moats, Carl F.....4007 S. Wayne Ave. (6)
Moats, George E.....421 E. Wayne St. (2)
Moravee, Arthur E.....705 Lincoln Tower (2)
Mortenson, L. J...214 Wayne Pharmacal Bldg. (2)
Mueller, Lawrence W....3423 S. Wash. Rd. (6)
Murdock H. L....521 Wayne Pharmacal Bldg. (2)
Nahrwold, E. W...432 Wayne Pharmacal Bldg. (2)
Nill, John H.....1024 S. Barr St. (2)
O'Rourke, Carroll.....604 W. Berry St. (2)
Oyer, John H.....2707½ S. Calhoun St.
Parker, Carey B.....1105 S. Harrison St.
Perrin, Kermit F.....2701 S. Anthony St.
Popp, Milton F...610 Wayne Pharmacal Bldg. (2)
Porter, Miles F., Jr.....501 Dime Bank Bldg. (2)
Prentiss, Nelson H.....276 Central Bldg. (2)
Rabson, Salem M.....St. Joseph Hospital
Ranke, John W. Henry (H)..3112 Beaver Ave. (6)
Rawles, Lyman T.....3131 Fairfield (6)
Ray, Herbert A....402 Wayne Pharmacal Bldg. (2)
Rhamy, B. W.....516 Wayne Pharmacal Bldg. (2)
Rice, Wilkie B.....1101 E. Pontiac St. (5)
Rissing, Walter J.....1706 Sherman St. (7)
Roekey, Noah A.....1224 E. State Blvd. (3)
Rodriguez, Juan.....2902 S. Fairfield Ave. (6)
Roser, Arthur J.....617 W. Washington St.
Rossiter, Dudley L.....2615½ Calhoun St. (5)
Rothberg, Mauriee.712 Wayne Pharmaeal Bldg. (2)
Rothschild, C. J...319 Wayne Pharmacal Bldg. (2)
Sahlman, Hans.....1320 Broadway (2)
Salon, Harry W.....535 W. Berry St. (2)
Salon, Nathan L...220 Wayne Pharmacal Bldg. (2)
Savage, Arthur R.....302 W. Berry St. (2)
Schellhouse, Earl M.....1240 W. Main St. (7)
Schick, Martin F. (H)....401 W. Washington (2)
Schlegel, Edward H.....1129 Maumee Ave (4)
Schmoll, Robert J.....St. Joseph Hospital (2)
Schwartz, David I..715 Wayne Pharmacal Bldg. (2)
Scott, H. Vaughn.....2902 Fairfield Ave. (6)
Senseny, Herb M...314 Wayne Pharmacal Bldg. (2)
Shinaberry, Lawerence.....1850 Broadway (6)
Short, John T.....2902 Fairfield Ave. (6)
Singer, Elmer C...310 Wayne Pharmacal Bldg. (2)
Somer, Gerald H...2506 Lower Huntington Rd. (8)
Sparks, A. Jerome.323 Wayne Pharmacal Bldg. (2)
Stellner, Howard.....928 Ewing St.
Stier, Paul L.....304 Wayne Pharmacal Bldg. (2)
Stoler, Albert E.....278 Central Bldg.
Tennant, David L.....811 Ewing (2)
Tennant, Lewis W.....3409 Clinton Ct.
Terrill, Richard W.....1429 Lincoln Tower (2)
Thimlar, James W.....602 E. Lewis (2)
Thompson, Holland Irene Byron Sanitarium
Thornton, Walter E.....Lincoln Nat. Life Ins. Co.
Titus, Philip S.....1103 S. Barr St. (2)
Van Buskirk, E. M..525 Wayne Pharmacal Bldg. (2)
Walker, Floyd B.....610 E. Pontiac St. (5)
Wallace, J. Clifford.....4003 Harrison
Welty, Scudder G.....2702½ S. Calhoun St. (5)
Wilkins, Robert W.....2902 Fairfield Ave. (6)
Willett, Irving H.....Fort Wayne
Williams, Aubrey H.....2902 Fairfield Ave. (6)
Wilson, Leslie....418 Wayne Pharmacal Bldg. (2)
Wilson, Roland B.....1207 S. Lafayette St. (2)
Worley, Ansel C...317 Wayne Pharmacal Bldg. (2)
Wright, Wm. C....621 Wayne Pharmacal Bldg. (2)
Wyatt, James L. III.....233 E. Jefferson St. (2)
Wyatt, James L.....232 E. Jefferson St. (2)
Zehr, Noah.....301 W. Creighton (6)
Zweig, Elmer S.....344 W. Berry St. (2)
Mast, Karl F.....Angola
Emme, Richard W.....Harlan
Steinman, Henry E.....Monroeville
Uhrich, John Monroeville
Emenhiser, Donald C.....New Haven
Emenhiser, John L.....New Haven
Dahling, C. W.....New Haven
Hoetzer, Eldore M.....New Haven
Smith, Grover A.....New Haven
Williams, Almeda B.....New Haven
Moser, Edward.....Box 65, Woodburn
Engelbert, William F.....Tuscaloosa, Ala.
Chester, Herbert R.....Spring Creek Ranch, Cottonwood, Ariz.
Bailey, Perry W...354 W. 6th S., Claremont, Calif.
Whitten, Kathryn M.....2126 E. Live Oak St., Los Angeles, Calif.
Swanson, John.....2721 12th St., N. St. Petersburg, Fla.
Havice, Jay F.....Asheville, N. C.
Hayes, John J.....R. R. 4, Holland, Mich.
Velkoff, Metodi.....Box 413, Warren, O.
Johnston, D. D.....Veterans Administration, Sioux Falls, S. D.
Weissman, Irving.....3422 Lake Mendata Dr., Madison 5, Wis.

BARTHOLOMEW-BROWN COUNTIES

Adler, David L.....Columbus
Barrett, Daniel C.....Columbus
Beggs, Lowell F.....Columbus
Benham, James W. (H).....Columbus
Carpenter, Thomas D.....Columbus
Davis, Marvin R.....Columbus
Fisher, Walter S.....Columbus
Hart, Robert B.....Columbus
Hawes, James K.....Columbus
Hawes, Marvin E.....Columbus
Kamman, Herman H.....Columbus
Kirkpatriek, Alva M. (H).....Columbus
Macy, George W.....Columbus
Norton, Harold J.....Columbus
Norton, William J. (H).....Columbus
Overshiner, Lyman Columbus
Ryan, William J.....Columbus
Schmitt, Richard K.....Columbus
Sigmund, William B.....Columbus
Suverkrup, Lotta R. A. (H).....Columbus
Teal, Dorothy D.....Columbus
Williams, Everett W.....Columbus
Winebrenner, John D.....Columbus
Wissman, William L.....Columbus
Wood, Elmer U. (H).....Columbus
Yoder, Dewey D.....Columbus
Zaring, Byron K.....Columbus
Delong, Orville A. (H).....Elizabethtown
Dagley, Hubert R.....Hope
Dudding, Joseph E.....Hope
Reed, Lewis D. (H).....Hope
Marshall, Byron W.....Nashville

BENTON COUNTY

Taylor, Wade H.....Ambia
Atkinson, Charles W.....Boswell
Muller, L. P.....Boswell
Douglas, William Earl Park
Altier, William H.....Fowler
Mavity, David E. (H).....Fowler
Turley, Verne L.....Fowler
McCabe, James E.....Otterbein
Parker, Ernest E.....Oxford
Scheurich, Virgil Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H.....Jamestown
Schaaf, Alvin D.....Jamestown
Ballard, Robert J.....Lebanon
Beck, Herma A.....Lebanon
Coons, John D.....Lebanon
Headley, Lloyd M.....Lebanon
Higgins, Otis C.....Lebanon
Kern, Clarence G.....Lebanon
Porter, John R.....Lebanon
Rainey, Everett A.....Lebanon
Spieth, William H.....Lebanon
Weddle, Charles O.....Lebanon
Wisecheart, Robert H Lebanon
Ellis, Lyman H.....Lizton
Bassett, Claney Thorntown
Bassett, Margaret A.....Thorntown
Owsley, Guy M.....Thorntown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J.....Zionsville
Lovett, Harvey Zionsville

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

Kennedy, Eva N.....Camden
Wise, Charles L.....Camden
Carney, Calvin E. (H).....Delphi
Clauser, Albert C.....Delphi
Crampton, Charles C.....Delphi
Gros, Hubert Delphi
Wagoner, George W.....Delphi
Adams, Max R.....Flora
McLaughlin, James R.....Flora
Mullin, Herbert Y.....Rockfield
Brookie, Roger W.....Battle Creek, Mich.
Beamer, George D.....23810 Michigan Ave., Dearborn, Mich.

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael.....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Charles A.....325½ E. Market St.
Bradfield, John C.....408 North St.
Brown, DeWitt.....Logansport State Hospital
Canada, Clement.....314 Grove St.
Chapin, Charles C.....Logansport State Hospital
Cline, George W.....Logansport State Hospital
Cooper, Thomas L.....408 North St.
Davis, John C.....Masonic Temple
Egan, Burton W.....2305 Broadway
Fitzgerald, Brice E.....2127 North St.
Hedde, Eugene L.....309 Seventh St.
Hickman, Warren R.....211 S. Third St.
Hillis, Lowell J.....203 S. Third St.
Hochhalter, Marian.....307 Barnes Bldg.
Holloway, William A. (H).....201 S. Third St.
Holmes, Will W.....Masonic Temple
Jewell, Earl B.....2019 High St.
Keefe, Thomas L.....900 E. Broadway
Kimbrough, Robert F.....1203 High St.
Maxwell, John B. (H).....321½ E. Broadway
O'Leary, Francis T.....Logansport
Schenk, Foss.....Logansport State Hospital
Shultz, Harry M.....412 Fourth St.
Stanton, James J.....220 South Sixth St.
Stewart, Milton B.....308½ Fourth St.
Terflinger, Fred W.....422 North St.
Viney, Charles L.....Masonic Temple
Wilson, Paul H.....422 North St.
Winter, Donald K.....422 North St.
Newcomb, William K.....Royal Center
Rollins, Russell.....Royal Center
Flanagan, Estle P.....Walton
Lybrook, Daniel E.....Young America
Siewert, Otto L.....245 Lawndale, Aurora, Ill.
Little, John A..1868 Sheridan Rd., Evanston, Ill.
Barnett, Wm. E..3520 Fairmount St., Dallas, Tex.

CLARK COUNTY

Bottorff, David.....Charlestown
Goodman, Eli.....Charlestown
Marshall, Thomas J.....Charlestown
Worley, Henry L.....Henryville
Adair, Samuel L.....Jeffersonville
Baldwin, John H.....Jeffersonville
Bizer, Mier.....Jeffersonville
Bruner, Ralph W.....Jeffersonville
Buckley, Ernest P.....Jeffersonville
Burman, Richard G.....Jeffersonville
Carlberg, Dale.....Jeffersonville
Carney, Joel T.....Jeffersonville
Dare, Lee A.....Jeffersonville
Gudenkauf, Elton B.....Jeffersonville
Huoni, John S.....Jeffersonville
Isler, Nathaniel C.....Jeffersonville
Reeder, Henry H.....Jeffersonville
Varble, William M.....Jeffersonville
Weems, Mallory P.....Jeffersonville
Wilber, Harold R.....Jeffersonville
Regan, George L.....Sellersburg
Vandevert, Arthur C.....Sellersburg

CLAY COUNTY

Dilley, Fred C.....Brazil
Lambert, Junius L. (H).....Brazil
Maurer, James F.....Brazil
Maurer, Robert M.....Brazil
Muncie, Henry L.....Brazil
Palm, John M.....Brazil
Pell, Harry M.....Brazil
Shattuck, John C.....Brazil
Sourwine, Clint C.....Brazil
Weaver, Timothy M. (H).....Brazil
Webster, Robert K.....Brazil
Wood, Opal L.....Brazil
VanSandt, James W.....Carbon
Bond, Walter C.....Clay City
Rentschler, Lewis C.....Clay City
Ward, Harry H.....Coalmont
McIntosh, Wilbert.....Cory

CLINTON COUNTY

Harshman, Martin L.....Colfax
Wisehart, William H. (H).....Colfax
Applegate, Albert E.....Frankfort
Beardsley, Frank A.....Frankfort
Burroughs, Carroll A.....Frankfort
Carrel, Francis E.....Frankfort
Chittick, Archibald G.....Frankfort
Compton, Charles B.....Frankfort
Dykhuizen, Theodore A.....Frankfort
Erdel, Milton W.....Frankfort
Hamilton, Alexander.....Frankfort
Hammersley, George K.....Frankfort
Hedgcock, Robert A.....Frankfort
Holmes, Claude D.....Frankfort
Jones, William W.....Frankfort
Robison, Claude A.....Frankfort
Royster, Hollace R.....Frankfort
Sims, Stephen B. (H).....Frankfort
VanKirk, John A.....Frankfort
Work, Bruce A.....Frankfort
Mount, William C.....Kirklin
Carlyle, Ivan E.....Michigantown
Combs, Nelson B.....Mulberry
Kent, John A.....Mulberry
Grove, Robert H.....Rossville
Ketcham, John S.....Rossville

CRAWFORD COUNTY

Fouts, Joseph R.....English
Gobbel, Novy E.....English
Deen, Henry H.....Leavenworth
Benz, Jesse.....Marengo
Johnson, Jess J.....Milltown
Lynch, Otis R.....Louisville, Ky.

DAVIESS-MARTIN COUNTIES

Norton, Horace.....Crane
Porter, MacGuyer (H).....Elnora
Rohrer, James R.....Elnora
Eifert, Elmer E.....Loogootee
Lett, Emory B.....Loogootee
Strange, John W.....Loogootee
McCracken, Jacob O.....Montgomery
Coleman, Henry G.....Odon
Gilkison, John S.....Shoals
Arthur, Nora M.....Washington
Blazey, Arthur G.....Washington
Burress, Bert O.....Washington
Chattin, Vance J.....Washington
Cochran, Ralph B.....Washington
Fox, Chester P.....Washington
Lindsay, Hamlin B.....Washington
McKittrick, Jack.....Washington
McKittrick, William O.....Washington
McNaughton, Lawrence M.....Washington
McPherson, Solomon L. (H).....Washington
Rang, Arthur A.....Washington
Shields, Harry A.....Washington
Smoot, Emory B.....Washington
Wadsworth, Heilman C.....Washington

DEARBORN-OHIO COUNTIES

Duncan, William F. (H).....Aurora
Jackson, John K.....Aurora
Jackson, John M.....Aurora
Olcott, Charles W.....Aurora
Stewart, Omer H.....Aurora
Treon, James F.....Aurora
Wallace, Edward R.....Aurora
McNeely, Matthew J.....Dillsboro
Elliott, John C.....Guilford
Fagaly, Arthur T. (H).....Lawrenceburg
Fagaly, William J.....Lawrenceburg
Pfeifer, James M.....Lawrenceburg
Streck, Francis A.....Lawrenceburg
Fessler, Gordon S.....Rising Sun
Manley, Charles N.....Rising Sun
Fletcher, Charles F.....Sunman
Drohan, Edward P.....Winton Pl., Cincinnati, O.

DECATUR COUNTY

Tremain, Milton A.....Adams
Acher, Robert P.....Greensburg
Blemker, Russell M.....Greensburg
Callaghan, Winship C.....Greensburg
Dickson, Dale D.....Greensburg
Mahuron, Boyd L.....Greensburg
McKee, Harley S.....Greensburg
Morrison, Clyde C.....Greensburg
Morrison, James T.....Greensburg
Mullikin, Clarence W.....Greensburg
Overpeck, Charles.....Greensburg
Riley, Eden T. (H).....Greensburg
Sanders, Ira M. (H).....Greensburg
Harkcom, Harry E.....St. Paul
Porter, Edward A.....Westport
Wood, Charles.....Westport

DEKALB COUNTY

Covell, Harry M.....Auburn
Geisinger, Lewis N.....Auburn
Hines, Archie V.....Auburn
Hines, Dorsey M.....Auburn
Nugen, Harold.....Auburn
Rogers, Evered E.....Auburn
Sanders, Jesse A.....Auburn
Souder, Bonnell M.....Auburn
Stewart, Charles S. (H).....Auburn
Hathaway, Clayton B.....Butler
Weirich, Charles I.....Butler
Jinnings, Loren E.....Garrett
Kantzer, Floyd B.....Garrett
Nason, Robert A.....Garrett
Reynolds, D. Monroe.....Garrett
Reynolds, Russell P.....Garrett
Walsh, Thomas P.....Garrett
Ish, Etban A.....Waterloo
Showalter, John P.....Waterloo
Van Nest, Willard A.....New Smyrna Beach, Fla.
Swarts, Willard W.....803 Walnut St., Three Rivers, Mich.

DELAWARE-BLACKFORD COUNTIES

Puterbaugh, Karl E.....Albany
Hurley, John R.....Daleville
Tucker, Oral A.....Daleville
Hall, Emory H.....Dunkirk
Ames, George F. (H).....Eaton
Langsdon, Fred R.....Gaston
Dando, George H. (H).....Hartford City
Dodds, James U.....Hartford City
Morris, Jean W.....Hartford City
Owsley, Charlotte E. M.....Hartford City
Owsley, Guy A.....Hartford City
Scott, George E.....Hartford City
Werry, Leslie E.....Hartford City
Burns, Paul E.....Montpelier
McKean, Thomas J.....Montpelier

Muncie

Adams, William B.....Ball Memorial Hospital
Ball, Clay A.....303 W. Adams St.
Bibler, Henry E.....311 W. Adams St.
Bowles, John H.....417 Wysor Bldg.
Brown, Karl T.....503 Johnson Bldg.
Bunch, Rollin H.....400 E. Jackson St.
Butterfield, Robert M.....315 W. Jackson St.
Clauser, Eldo H. M.....315 S. Jefferson St.
Clevenger, Joseph H.....315 S. Jefferson St.
Cole, Russell E.....203 Western Reserve Bldg.
Covalt, Wendell E.....216 S. High St.
Cure Elmer T.....105 Western Reserve Bldg.
Davis, Edgar C.....107 Plaza Bldg.
Deardorff, Oliver M.....217 W. Charles St.
DeFries, John.....420 W. Washington St.
Deutsch, William.....309 Johnson Bldg.
Dunn, Ferrell W.....118 S. Franklin St.
Funk, John W.....217 W. Charles St.
Garling, Luvern C.....420 W. Washington St.
Hall, Orville A.....205 Western Reserve Bldg.
Hayes, Theodore R.....210 S. High St.
Henderson, Ramon A....104 Western Reserve Bldg.
Hill, Howard E.....402 W. Jackson St.
Hill, Robert E.....215 W. Jackson St.
Hurley, Anson G.....110 N. Cherry St.
Imhof, Joseph D.....206 Western Reserve Bldg.
Kemper, Arthur T. (H).....112 W. Adams St.
Kern, Charles B.....715 E. Washington St.
Kirshman, Forrest E.....211 S. High St.
LaDuron, Jules F.....517 S. Liberty St.
Leatherman, Cameron A.....313 E. Howard St.

DELAWARE-BLACKFORD COUNTIES—(Cont.)

Muncie

Mason, Lester R.....401 W. Jackson St.
McClellan, John B.....Muncie
McMichael, Robert M.....316 W. Adams St.
Molloy, William J.....124½ E. Main St.
Montgomery, Lall G.....Ball Memorial Hospital
Moore, William C.....110 N. Cherry St.
Morford, Guy Ball Memorial Hospital
Mulcahy, Bernard J...418-420 W. Washington St.
Owens, Richard R.....406 Western Reserve Bldg.
Owens, Thomas R.....202 Western Reserve Bldg.
Quick, William J.....314 E. Washington St.
Rettig, Arthur C.....314 W. Jackson St.
Scantland, Willard A.....Ball Memorial Hospital
Schulhof, Maurice G...418-420 W. Washington St.
Silvers, James M.....220 W. Adams St.
Silvers, Joseph C.....319 S. Franklin St.
Smith, James S.....501 Kirby Ave.
Spurgeon, Orville E.....310 S. Washington St.
Stocking, Bruce W.....Ball Memorial Hospital
Tindal, Edward F. (H).....214 Wysor Bldg.
Turner, Robert D.....217 S. Liberty St.
Venis, Kemper N.....101 S. Franklin St.
Vlaskamp, Elaine M.....401 W. Main St.
Walters, Lindsey O.....303 Wysor Bldg.
Williams, John H.....306 E. Jackson St.
Wood, Amelia T.....2004 Petty Rd.
Young, Gerald S.....316 W. Jackson St.
Kilgore, Frank T.....Yorktown
Moss, Mavor J.....Yorktown
Wasley, Malcolm T.....Antioch, Calif.
Owsley, Robert W.....1136 W. 6th Ave., Los Angeles, Calif
Aucreman, Charles J..City Hospital, 3395 Scranton Rd., Cleveland, O.
McClintock, James A...Louisville General Hospital, Louisville, Ky.
Lyons, Charles R.....Drummond, Mont.
Gwartney, Richard H.....300th General Hospital, APO 782, c/o Postmaster, New York, N. Y.
Covalt, Donald A...Rm. 884 Veterans Admistration Bldg., Washington, D. C.
Covalt, Nila K...Rm. 884 Veterans Administration Bldg., Washington, D. C.

DUBOIS COUNTY

Backer, Henry G.....Ferdinand
Take, John F.....French Lick
Bretz, Waverly D.....Huntingburg
Lukemeyer, Edward G. (H).....Huntingburg
Lukemeyer, Louis C. (H).....Huntingburg
McKinney, Sherman L.....Huntingburg
Steinkamp, Emil F.....Huntingburg
Stork, Harvey K.....Huntingburg
Williams, Fielding P.....Huntingburg
Blessinger, Paul J.....Jasper
Casper, John P.....Jasper
Casper, Joseph F.....Jasper
Heck, Martin C.....Jasper
Held, George A.....Jasper
Lukemeyer, St. John Jasper
Salb, Leo A.....Jasper

ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

Elkhart

Arlook, Theodore D.....409 Baldwin St.
Bender, Robert L.....405 S. Second St.
Bloom, George R.....131 Monger Bldg.
Bolin, Robert S.....122 W. Lexington
Bowdoin, George E.....123 W. Marion St.
Compton, Walter A.....901 Strong Ave.
Conklin, Raymond L.....1906 E. Jackson Blvd.
Cormican, Herbert L.....721 E. Marion St.
DeDario, Leonard M.....123 W. Marion St.
Dewey, Fred N. (H).....127 N. Fifth St.
Elliott, Lloyd A.....405 S. Second St.
Fleming, Claude F.....121 W. Marion St.
Fleming, Justus M.....123 W. Marion St.
Goodrum, William R.....127 W. Marion St.
Grossnickle, George W.....210 Equity Bldg.
Hull, Arthur W.....506 S. Second St.
Hunn, Maro F.....415 S. Second St.
Kistner, Arthur W.....123 W. Marion St.
Kistner, John W.....200 Equity Bldg.
Koehler, Elmer G.....Monger Bldg.
Lundt, Milo O.....519 S. Second St.
Markel, Ivan J.....215 W. Franklin St.
Mendez, Carlos.....116 W. Marion St.
Miller, Samuel T.....506 S. Second St.
Mishkin, Irving 181 Gage Ave.
Norris, Allen A.....208 W. Marion St.
Pfaff, William A.....208 W. Marion St.
Pancost Ruth Hoetzer.....No. 9, Melrose Manor
Pancost, Vernon K.....514 Equity Bldg.
Patrick, Glenn B.....427 S. Second St.
Schlosser, Herbert C.....116 W. Marion St.
Sears, Murray M.....303 Equity Bldg.
Stauffer, Walter A.....214 Equity Bldg.
Stout, Richard B.....1501 Greenleaf Blvd.
Swank, L. Forrest.....315 Equity Bldg.
Swihart, Leonard F.....214 W. Marion St.
Todd, David D.....414 S. Second St.
Vetter, Karl W.....131 Monger Bldg.
Wagner, Samuel C.....Monger Bldg.
Wilson, O. E.....217 N. Main St.
Work, James A., Jr.....412 S. Second St.

Goshen

Bartholomew, Mary L.....217 E. Lincoln Ave.
Bender, Cecil K.....115 E. Washington St.
Eby, Ida L.....131 S. Main St.
Freeman, Floyd M.....109 W. Washington St.
Hostetler, Carl M.....304 E. Lincoln Ave.
Kelly, William R.....215 N. Main St.
Lemon, Herbert K.....Shoots Bldg.
Martin, Floyd S.....127 E. Lincoln
Miller, Malcolm E.....Spohn Bldg.
Simmons, Lloyd H.....Goshen
Vander Bogart, Harry E.....31 Shoots Bldg.
Yoder, Albert C.....113 S. Fifth St.
Yoder, Jonathan G.....214 E. Lincoln Ave.
Young, Ralph H.....103 E. Madison
Farver, Moses A.....Middlebury
Norris, Ernest B.....Middlebury
Teters, Melvin S.....Middlebury
Chandler, Leon H.....Millersburg
Fleetwood, Raymond A.....Nappanee
Kendall, Forest M.....Nappanee
Price, Douglas W.....Nappanee
Price, Melvin D.....Nappanee
Price, Willard A. (H).....Nappanee
Slabaugh, Janey S.....Nappanee
Slabaugh, Lotus M.....Nappanee
Stuckman, Edwin N.....New Paris
Studebaker, Lloyd R.....New Paris
Amick, Charles L.....Wakarusa
Hannah, Jack W.....Wakarusa

FAYETTE-FRANKLIN COUNTIES

Foreman, Walter A.....Brookville
Glaser, Edward M.....Brookville
Hoeger, Hobart R.....Brookville
Seal, Perry F.....Brookville
Smith, Herbert N.....Brookville
Ashworth, Lewis N.....Connersville
Booher, Irvin E.....Connersville
Elliott, Roy Howe.....Connersville
Entner, Charles L.....Connersville
Gordin, Stanley B.....Connersville
Gordin, Stanton E. (H).....Connersville
Gregg, Albert F.....Connersville
Kemp, William A.....Connersville
Love, George N.....Connersville
Morrow, Roy D.....Connersville
Mountain, Francis B.....Connersville
Smelser, Herman W.....Connersville
Phillips, William R.....R. R. 1, Glenwood
Larkum, Newton W.....Kings Daughters Clinic, Temple, Texas

FLOYD COUNTY

Engleman, Harry K.....Georgetown

New Albany

Baker, Avey M.....811 E. Spring St.
Baxter, James W., Jr.....1201 E. Spring St.
Baxter, Samuel M.....1201 E. Spring St.
Briscoe, Clarence E.....1413 E. Spring St.
Brown, Kenneth H.....500 E. Spring St.
Byrn, Howard W.....415 Elsby Bldg.
Byrne, Basil K.....Elsby Bldg.
Cohn, Phillip Silvercrest Hospital
Davis, Dudley F 601 E. Spring St.
Davis, Parvin M.....601 E. Spring St.
Day, George H.....1252 Vincennes
Edwards, William F.....Floyd County Bank Bldg.
Garner, William H.....919 E. Spring St.
Gentile, John P.....1313 E. Spring St.
Habermel, John F.....415 Elsby Bldg.
Hauss, Augustus P.....Elsby Bldg.
Hewlett, Thomas H.....919 E. Spring St.
McCullough, James Y.....624 E. Spring St.
Pace, Jerome V.....Silvercrest Sanitarium
Paris, John M.....150 E. Spring St.
Pierson, Percy R.....203 Liberty State Bank Bldg.
Polhemus, Gretchen I.....1610 E. Spring St.
Robertson, Addis N.....820 E. Spring St.
Rogers, Sherman T. (H).....1017 E. Spring St.
Schoen, Phillip H. (H).....1825 State St.
Shacklett, Henry B.....511 Elsby Bldg.
Sloan, Herbert 1207 E. Spring St.
Spaulding, Earl M.....1207 E. Spring St.
Strange, Martin B.....1228 Vincennes St.
Streepey, Jefferson I.....309 Elsby Bldg.
Tyler, Frank T.....420 Vincennes St.
Voyles, Harry E.....213 Elsby Bldg.
Weaver, William W.....1104 E. Spring St.
Winstandley, William C.....815 Vincennes St.
Hofferkamp, August G.....State Tuberculosis Sanitarium, Louisville 9, Ky.

FRANKLIN COUNTY

(See Fayette-Franklin)

FOUNTAIN-WARREN COUNTIES

Fisher, John E.....Attica
Freed, James C.....Attica
Kerr, Alvin R.....Attica
Maris, Lee J.....Attica
Aldridge, James W.....Covington
Johnson, Earl E.....Covington
Stephens, Lowell R.....Covington
Bounell, Emery G.....Hillsboro
Ratcliff, A. Lonzo.....Kingman
Smith, Byron J.....Kingman
Himebaugh, Gilbert J.....Veedersburg
McCord, Carl Byron.....Veedersburg
Rusk, Hubert M.....Wallace
Heald, Walter W.....West Lebanon
Davisson, Carl V.....Williamsport
Haller, Thomas C.....Williamsport
Owens, John.....104 E. 20th St., Houston, Tex.

FULTON COUNTY

Herrick, Charles L.....Akron
Miller, Virgil Akron
Connell, Vactor O.....Fulton
Dielman, Franklin C.....Fulton
Kelsey, Lawrence E.....Kewanna
Kraning, Kenneth K Kewanna
Herendeen, Elbie V.....Rochester
King, Milo O.....Rochester
Markley, Henry W.....Rochester
Richardson, Charles L.....Rochester
Rowe, Howard H.....Rochester
Stinson, Arthur E.....Rochester
Stinson, Dean K.....Rochester

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Klein, Hilbert P.....Fort Branch
Morris, William F.....Fort Branch
Marchand, Austin F.....Haubstadt
Marchand, Edwin V.....Haubstadt
Petitjean, Harold G.....Haubstadt
Arthur, Hamilton M.....Hazelton
Clark, Carl M.....Oakland City
Ropp, Eldon R.....Oakland City
Wood, Russell W.....Oakland City
Wood, William B.....Oakland City
Beresford, George B. (H).....Owensville
Montgomery, James R.....Owensville
Strickland, Karl S.....Owensville
Alexander, Harry H.....Princeton
Brazelton, Osborne T.....Princeton
Carpentier, Harry F.....Princeton
Folek, John K.....Princeton
Graves, Orville M.....Princeton
Hollingsworth, Marshall P. (H).....Princeton
McCarthy, Virgil Princeton
McElroy, Robert S.....Princeton
Miller, Charles A.....Princeton
Rhodes, Amos H.....Princeton
Childs, Wallace E...136 Lovington Dr., Fairfield, O.

GRANT COUNTY

Henley, Glenn Fairmount
Holliday, L. D. Fairmount
McCartney, Donald H. Fairmount
Seale, Joseph P. Fairmount
Garrison, Leon J. Gas City
Tavenner, Fred W. Gas City
Baskett, Russell J. Jonesboro

Marion

Abell, Charles F. 321 National Bank Bldg.
Ayres, Wendell W. 312 Iroquois Bldg.
Bloom, Asa W. 407 Glass Block
Boyer, Grace M. 307 Glass Block
Braunlin, Robert F. 718 Marion Nat. Bank Bldg.
Braunlin, William H. 712 Marion Nat. Bank Bldg.
Brown, Robert M. 521 Marion Nat. Bank Bldg.
Daniels, Erle O. 708 Marion Nat. Bank Bldg.
Daniels, George R. 324 Glass Block
Davis, Joseph B. 723 Euclid Ave.
Davis, Merrill S. Marion Nat. Bank Bldg.
Davis, Richard 723 Euclid Ave.
Diamond, Leo L. 612 Marion Nat. Bank Bldg.
Eshleman, Lindley H. (H) 2927 S. Washington St.
Fisher, Henry 1501 S. Washington St.
Fisher, Pierre J. 2928 S. Washington St.
Ganz, Max 930 S. Adams St.
Ginsberg, Stewart T. Veterans Administration
Huff, Asher D. 310 Glass Block
Hummel, Russel M. 204 Marion Nat. Bank Bldg.
Jones, Ernest F. Veterans Hospital
Kimball, Glen D. 302 Glass Block
Lavengood, Russell W. 511 Glass Block
List, Harold E. 612 Marion Nat. Bank Bldg.
Long, Max R. 8th and Boots Sts.
McIlwain, Eleanor E. 107 E. 31st St.
McIlwain, Robert E. 107 E. 31st St.
McKay, James D. (H.) 413 Marion Nat. Bank Bldg.
Miller, H. Allison 321 Glass Block
Post, Edward S. Veterans Administration
Powell, J. Paxton Marion
Powell, Nettie B. (H) 615 Whites Ave.
Price, Sidney 311 Glass Block
Renbarger, Lester L. 1531 W. Second St.
Rhorer, John G. 201 S. D St.
Skomp, Claud E. Marion General Hospital
Van Dorn, Myron J. Veterans Administration
Warren, Carroll B. Marion
Weinberg, Samuel 318 Glass Block
Weinstein, Louis Veterans Administration
Young, Robert G. 2927 S. Washington St.
King, Peter C. Swayzee
Burge, Aaron D. Sweetzers
Taylor, Everett C. Upland
Derbyshire, John E. Van Buren
Nyce, Holst W. Van Buren
Bourke, William W. Fort Meade, S. D.
Faust, Walter H. Veterans Administration, Little Rock, Ark.
Loomis, John F. (H) 2749 6th Ave., St. Petersburg, Fla.
Ritchey, John A. West Salem, Ore.
Stewart, James H. Duke Hospital, Durham, N. C.

GREENE COUNTY

Graf, Jerome A. Bloomfield
Hull, King L. Bloomfield
Mount, Mathias S. Bloomfield
Turner, Harold B. Bloomfield
Van Sandt, Frank A. Bloomfield
Porter, Carl M. Jasonville
Rotman, Harry G. Jasonville
Rotman, Sam I. Jasonville
Bailey, Edwin B. Linton
Berns, Peter C., Jr. Linton
Craft, William F. Linton
Porter, George C. Linton
Raney, Ben B. Linton
Tomak, Milton E. Linton
Woner, John W. Linton
Simons, James S. (H) Lyons
Hamilton, M. Luther Newberry
Fender, Asa H. Worthington
Moses, George E. Worthington
Moses, Robert E. 463 A.A.F., B.U. Squad E, Geiger Field, Spokane, Wash.

HAMILTON COUNTY

Rodenbeck, Frank Arcadia
McDaniel, Franklin P. Atlanta
Cooper, Ross A. Carmel
Donahue, Claude M. Carmel
Havens, Edward D. Cicero
Havens, Oscar Cicero
Tomlinson, Carlton H. (H) Cicero
Ambrose, Jesse C. Noblesville
Harris, Robert F. Noblesville
Hash, John S. Noblesville
Hooke, Samuel W. Noblesville
Klotz, Joseph G. Noblesville
Kraft, Haldon C. Noblesville
Shanks, Ray Noblesville
Southard, Carl B. Noblesville
Thayer, Joseph O. Noblesville
Griffith, James W. Sheridan
Newby, Alonzo C. Sheridan
Reck, John L. Sheridan
Young, Edward M. Sheridan
Connoy, Andrew F. Westfield
Loveless, Phillip H. 323 E. Colter Windsor Sq., Phoenix, Ariz.
Havens, Russell E. 622 E. Cuyler Ave., Oak Park, Ill.

HANCOCK COUNTY

Scott, Robert O. Charlottesville
Ferrell, Jesse E. Fortville
Ferrell, Mars B. Fortville
Hervey, Samuel W. (H) Fortville
Navin, Hugh K. Fortville
Allen, Joseph L. Greenfield
Arnold, Ralph N. Greenfield
Bruner, Charles H. Greenfield
Gibbs, Charles M. Greenfield
Gill, Dee D. Greenfield
Heller, Oscar S. Greenfield
Kinneman, Robert E. Greenfield
Rariden, Lawrence B. Greenfield
Woods, James R., Jr. Greenfield
Godwin, J. David New Palestine
Larrabee, William H. New Palestine
Mace, Elmer E. New Palestine
Pierson, Thomas A. New Palestine
Gibbs, Earl R. Wilkinson
Kuhn, Robert W. Wilkinson
Titus, Charles R. Wilkinson
Andrews, Cecil Naval Medical Center, Bethesda, Md.
Romack, Howard H. Mary McClellan Hospital, Cambridge, N. Y.

HARRISON COUNTY

Amy, William E. Corydon
Applegate, Frederick M. Corydon
Clunie, William Corydon
Dillman, Carl E. Corydon
Baker, Guy D. Crandall
Bierly, Fred Elizabeth
Murphy, Edgar W. Lanesville
Mathys, Alfred Mauckport
Glenn, Lafayette Ramsey

HENDRICKS COUNTY

Foltz, Lloyd E. Brownsburg
Scudder, Arthur N. Brownsburg
LaBonte, Napoleon Clayton
Tyner, Harlan H. Clayton
Ellett, John, Jr. Coatesville
Frantz, Mount E. Danville
Gibbs, Joseph W. Danville
Huckleberry, Carl D. Danville
Price, Ernest H. Danville
Wiseheart, Oscar H. North Salem
Scamahorn Oscar T. Pittsboro
Aiken, Milo M. Plainfield
Smith, Joseph S. Plainfield
Stafford, James C. Plainfield
Stafford, William C. Plainfield
Thomas, Clarkson B. Plainfield
Jones, Rilus E. 215 E. 84th Pl., Los Angeles 3, Calif.
Morgan, Hallie I. 217 Observatory, Ann Arbor, Mich.

HENRY COUNTY

Call, Earl B. Knightstown
Craig, Alexander Knightstown
Dreyer, Ralph W. Knightstown
Harvey, Bennett B. Knightstown
Waller, John I. Knightstown
Arford, Roxford D. Middletown
Dragoo, Farrol Middletown
Hill, Kenneth Middletown
Marshall, Lloyd C. Mt. Summit
Amos, Robert L. New Castle
Bitler, Clyde C. New Castle
Blaize, Joshua A. New Castle
Bledsoe, James G. New Castle
Burnett, Arthur B. New Castle
Canaday, Clifford E. New Castle
Harrison, Benjamin L. New Castle
Heilman, William C. New Castle
Iterman, George E. New Castle
Kennedy, Walter U. New Castle
Life, Homer L. New Castle
McElroy, James S. New Castle
Piper, Mark M. New Castle
Scheetz, Marion R. New Castle
Smith, Robert A. New Castle
Spindler, Robert D. New Castle
Stout, Walter M. New Castle
Thorne, Charles E. New Castle
Tully, John A. New Castle
Van Nuys, Walter C. New Castle
Westhafer, Edison K. New Castle
Wiggins, Dulania S. New Castle
Wiggins, George New Castle
Wright, Walter W. New Castle
Wilson, Ralph (H) Shirley
Robertson, William S. Spiceland
Roberts, Floyd N. 224 S. Mt. Vernon, Prescott, Ariz.

HOWARD COUNTY

Denton, Larkin D. Greentown
Shoup, Homer B. Greentown

Kokomo

Adams, Charles J. 618 Armstrong-Landon Bldg.
Boughman, Joe D. 322 Armstrong-Landon Bldg.
Bowers, Copeland C. 210 W. Mulberry St.
Bowers, Garvey B. 210 W. Mulberry St.
Bowers, John A. 210 W. Mulberry St.
Bruegge, Theodore J. 632 Armstrong Landon Bldg.
Clarke, Elton R. 400½ N. Main St.
Conley, Thomas M. 520 Union Bank Bldg.
Craig, Reuben A. 608 Armstrong-Landon Bldg.
Cuthbert, Frederick S. Citizens Bank Bldg.
Druley, Garner N. 518 Armstrong-Landon Bldg.
Ferry, Paul W. 406 Union Bank Bldg.
Good, Richard P. 308 Armstrong-Landon Bldg.
Harrison, William H. (H) 318½ N. Main St.
Hutto, William H. 408 Armstrong-Landon Bldg.
Knepple, LaMarr R. 514 N. Washington St.
Lung, Bruce D. 410 Union Bank Bldg.
McIndoo, Ralph E. 304 W. Walnut St.
Martin, William J. 112½ W. Mulberry St.
Meiner, Joseph A. 911 S. Main St.
Morrison, David A. 504 Union Bank Bldg.
Morrison, William R. 504 Union Bank Bldg.
Murray, Frederick N. 301 W. Markland St.
Paris, Durward W. 614 Armstrong-Landon Bldg.
Rhorer, Herbert M. Citizens Nat. Bank Bldg.
Rhorer, Roger J. Kokomo
Schuler, Russell P. 200½ N. Main St.
Scott, Russell F. Union Bank Bldg.
Shenk, Earl M. 208½ N. Main St.
Spangler, Jesse S. 215 E. Taylor St.
Wilson, Fred M. 414 Union Bank Bldg.
Wooldridge, Omer R. R. No. 6, Box 316A
Evans, Robert M. Russiaville
Rhorer, Roger J. Midland, Tex.

HUNTINGTON COUNTY

Omstead, T. W. ... Andrews
Brubaker, Harold S. ... Huntington
Casey, Stanley M. ... Huntington
Erehart, Mark G. ... Huntington
Eviston, John B. ... Huntington
Galbreath, Russell S. ... Huntington
Gray, Paul M. ... Huntington
Grayson, Fred W. (H) ... Huntington
Grayston, Wallace S. ... Huntington
James, Thomas, Jr. ... Huntington
Johnston, Robert G. ... Huntington
Marks, Howard H. ... Huntington
Meiser, Robert D. ... Huntington
Mitman, Floyd B. ... Huntington
Nie, Grover M. ... Huntington
Ware, J. Roger ... Huntington
Wimmer, George G. ... Huntington
Woods, Halden C. ... Markle
Bigelow, Oliver P. ... Roanoke
Koontz, William A. ... Roanoke
Bennett, J. B. ... Warren
Black, Claude S. ... Warren
Bonifield, Harold F. ... Warren
Smith, Lucian ... Warren
Redding, Lowell G. ... 3707 Wager St., Detroit 6, Mich.

JACKSON COUNTY

Cummings, David J. ... Brownstown
Gillespie, Garland R. ... Brownstown
Shields, Jack E. ... Brownstown
Jenkins, James M. (H) ... Cortland
Adair, William K. ... Crothersville
Bard, Frank B. ... Crothersville
Conner, Thomas E. ... Freetown
Day, William D. C. ... Seymour
Elsner, Lawrence W. ... Seymour
Gillespie, Charles E. ... Seymour
Graessle, Harold P. ... Seymour
Kamman, George H. (H) ... Seymour
Martin, Guy ... Seymour
Miller, Harold E. ... Seymour
Osterman, Louis H. ... Seymour
Shortridge, Wilbur H. ... Seymour
Wright, Elmer C. ... Seymour
Abel, Virgil ... Vallonia

JASPER-NEWTON COUNTIES

Pippenger, Wayne G. ... Brook
O'Neill, Martin ... DeMotte
Openshaw, James F. ... Goodland
Ruhmkorff, Ralph H. ... Goodland
Glick, Orval E. ... Kentland
Mathews, Wilbur C. ... Kentland
VanKirk, George H. ... Kentland
Yegerlehner, Roscoe S. ... Kentland
Merchant, Raymond ... Lake Village
Himebaugh, J. R. S. ... Morocco
Larrison, Glenn D. ... Morocco
Schantz, Richard ... Remington
Sink, Frank G. ... Remington
Beaver, Ernest ... Rensselaer
Dick, Jack ... Rensselaer
English, Harry E. ... Rensselaer
Johnson, Cecil E. ... Rensselaer
Kresler, Leon ... Rensselaer
Washburn, Richard N. ... Rensselaer
Tate, Wallace W. ... Thayer
Gwin, Merle D. 2111 Regatto Ave., Sun Set Island, No. 4, Miami Beach, Fla.

JAY COUNTY

Garber, Erwin C. ... Dunkirk
Heller, Nelson L. R. ... Dunkirk
Oswalt, James T. ... Dunkirk
Peacock, Robert C. ... Dunkirk
Heistand, Harley J. ... Pennville
Badders, Ara C. ... Portland
Cring, George V. ... Portland
Engle, John M. ... Portland
Hammond, Stanley M. ... Portland
Keeling, Forrest E. ... Portland
Lyon, Florence ... Portland
Moran, Mark M. ... Portland
Morrison, George G. ... Portland
Nixon, Jesse E. ... Portland
Schwartz, William D. (H) ... Portland
Streib, Homer F. ... Portland
Spahr, Donald E. ... Portland
Lansford, John ... Redkey
Kidder, John J. ... Salamonia
Hiestand, Harley B. .. Hospital of the University of Pennsylvania, Philadelphia 4, Pa.

JEFFERSON COUNTY

Henning, Carl ... Hanover

Madison

Beetem, Luther F. ... 425 W. Main St.
Boner, George W. ... Madison State Hospital
Childs, Alpha G. W. ... 412 E. Main St.
Cook, Elbert C. ... Madison
Estel, Gottfried A. ... Madison State Hospital
Hamilton, Guy W. ... Clifty Hotel
Jolly, Lewis E. ... Madison
Kremer, Nicholas A. ... 322 E. Second St.
May, George A. ... 428 E. Main St.
Modisett, Jackson W. ... Odd Fellows Bldg.
Modisett, Marcella S. ... Madison
Moore, Martha ... Madison State Hospital
Prenatt, Francis ... Madison State Hospital
Sharman, Edward J. ... 610 E. Second St.
Shuck, William A. ... 403 W. Second St.
Sloan, W. K. ... Madison
Totten, Evan C. ... 415 W. Second St.
Turner, Anna L. ... 104 E. Third St.
Turner, Oscar A. ... 104 E. Third St.
Whitsitt, Schuyler A. ... 718 W. Main St.
Copeland, Charles C. (H) ... North Madison

JENNINGS COUNTY

Daubenheyer, Miles ... Butlerville
Robertson, David W. (H) ... Deputy
Green, John H. ... North Vernon
Grossman, William L. ... North Vernon
Matthews, Dennis W. ... North Vernon
Stemm, William H. (H) ... North Vernon
Thayer, Benet W. ... North Vernon

JOHNSON COUNTY

Michaels, Joseph F. ... Edinburg
Eaton, Lyman D. ... Franklin
Jones, Charles A. ... Franklin
Murphy, Harry E. ... Franklin
Pearce, Roy V. ... Franklin
Portteus, Walter L. ... Franklin
Province, Oran A. ... Franklin
Province, William D. ... Franklin
Records, Arthur W. ... Franklin
Wilson, Russell C. ... Franklin
Barnes, Helen Beall ... Greenwood
Brown, George E. ... Greenwood
Sheek, Kenneth I. ... Greenwood
Tiley, George A. ... Greenwood
Woodcock, Charles E. ... Greenwood
Machledt, John H. ... Whiteland
Menza, Michael J. ... Niagara-Hudson Clinic, Buffalo, New York

KNOX COUNTY

Byrne, Robert J. ... Bicknell
Fox, Richard H. ... Bicknell
Meade, Walter W. ... Bicknell
Wilson, Guy H. ... Bicknell
Scudder, John A. ... Edwardsport
Boyd, Nelson E. ... Freelandville
Hodges, William A. ... Oaktown
Springston, George H. ... Oaktown
Johnson, Ernest N. ... Sandborn
Pahmeier, John W. ... Sandborn

Vincennes

Albrecht, Joseph R. ... 200 Harrison Bank Bldg.
Anderson, Richard M. ... 301 LaPlante Bldg.
Arbogast, Paul B. ... 915 Main St.
Bailey, William A. ... 516 Busscron St.
Beckes, Ellsworth W. ... 414 Broadway
Boyd, Claudius L. ... 114 N. 4th St.
Chattin, Herbert O ... 321 LaPlante Bldg.
Coffel, Melvin H. ... 424 LaPlante Bldg.
Curtner, Myron L. ... 222 N. 6th St.
Fox, Maurice S. .. 223-30 American Natl Bank Bldg.
Gilmore, Louis L. ... 430 N. 2nd St.
Hoffman, Doris ... 324 Vigo St.
Humphreys, Joe E. ... 217 N. 3rd St.
Johnson, Morris H. C. ... 212 Harrison Bank Bldg.
Knapp, Adam B. (H) ... 401 LaPlante Bldg.
McCormick, Hubert D. ... 316 LaPlante Bldg.
McDowell, Mordecai M. .. 223 American Bank Bldg.
McMahan, Virgil C. ... LaPlante Bldg.
Meyer, Raymond C. ... Hillcrest Hospital
Moore, Robert G. ... 21 N. 3rd St.
Nance, William K. ... 324 Vigo St.
Ramsay, John P. (H) ... 606 Main St.
Reilly, James F. ... 418½ Main St.
Richards, D. H. (H) .215 American Natl Bank Bldg.
Schulze, William ... 223 American Bank Bldg.
Shaffer, Kenneth L. ... 404 LaPlante Bldg.
Small, Emery F. ... 729 Main St.
Spencer, Frederic ... 421 LaPlante Bldg.
Warren, John C. ... 1428 Burnett Lane
Lazo, Vincent R. ... Wheatland
Ewing, Nathaniel D. ... Section Hospital, Camp Knox, Ky.
Mock, Ernest L. ... Region Medical Officer, Custom House, New Orleans, La.

KOSCIUSKO COUNTY

Thomas, Charles E. ... Leesburg
Davis, Lloyd H. ... Mentone
Urschel, Dan ... Mentone
Hursey, Virgil G. ... Milford
Laird, Leslie A. ... North Webster
Herring, George N. ... Pierceton
Schuldt, T. S. ... Pierceton
King, James R. ... Silver Lake
Clark, Fred ... Syracuse
Craig, Robert A. ... Syracuse
Fosbrink, E. L. ... Syracuse
Dubois, Charles C. ... Warsaw
Hillery, John L. ... Warsaw
Richer, Orville H. ... Warsaw
Schlemmer, George H. ... Warsaw
Thomas, Everett W. ... Warsaw
Kress, Geo. L. .. Veterans Administration, Hines, Ill.

LAKE COUNTY

Crown Point

Becker, Philip H. .. Lake County T. B. Sanitarium
Birdzell, John P. ... 124 N. Main St.
Gray, Daniel E. ... 235 S. Main St.
Iddings, John W. ... 124 N. Main St.
Pettibone, Claude R. ... 224 S. Court St.
Seyler, Anna G. .. Lake County T. B. Sanitarium
Steele, Everett B. ... 124 N. Main St.
Trontwine, William ... 224 S. Court St.
Weis, William D. ... Court House
Adler, Edmund R. ... Dyer

East Chicago

Arnold, Marion F., Jr. ... 4614 Indianapolis Blvd.
Benchik, Frank A. ... 5001 Todd Ave.
Picknell, George F. ... 4712 Magoun Ave.
Bonaventura, Angelo P. ... 4614 Indianapolis Blvd.
Boyd, Charles S. ... 4739 Melville Ave.
Boys, Fay F. ... 722 W. Chicago Ave.
Brauer, Abraham A. ... 3528 Main St.
Braun, Benjamin D. ... St. Catherine's Hospital
Broomes, Edward L. ... 2301 Broadway
Callahan, Richard H. ... 3502 Main St.
Campagna, Ettro A. ... 3406 Guthrie
Carleton, Edward H. ... Inland Steel Co.
Cohen, Benjamin R. ... 3352 Michigan Ave.
Cotter, Edward R. ... 722 W. Chicago Ave.
Dainko, Alfred J. ... 623 W. Chicago Ave.
Ernst, Helmuth C. W. ... 720 W. Chicago Ave.
Fleischer, Jacob C. ... 3406 Guthrie St.
Govorchin, Alexander ... 724 W. Chicago Ave.
Grosso, William G. ... 722 W. Chicago Ave.
Hamilton, Robert C. ... 2602 E. 140th Place
Irish, Wilbur J. ... 806 W. Chicago Ave.
Johns, David R. ... 720 W. Chicago Ave.
Josif, Lazar ... 3701 Main St.
Kaplan, Benjamin B. ... 723 E. Chicago Ave.
Komoroske, John E. ... 723 E. Chicago Ave.
Levin, Eli ... 3700 Main St.
McGuire, Desmond F. ... 3429 Michigan Ave.
Marks, Ora L. ... 815 W. Chicago Ave.
Mervis, Frank H. ... 3414 Michigan Ave.
Nakadate, Katsumi J. ... 815 W. Chicago Ave.
Niblick, James S. ... 3406 Guthrie
Nicosia, John B. ... 3701 Main St.
Noe, Joseph T. ... Inland Steel Co.

LAKE COUNTY—(Cont.)

East Chicago

O'Connor, James J.....3701 Main St.
Ostrowski, Leonard J.....3701 Main St.
Payne, Arthur C.....2020 Broadway
Petronella, Samuel J.....4614 Indianapolis Blvd.
Schlicker, Alexander G. (H)..4711 Indpls. Blvd.
Shulruff, Harry I.....3701 Main St.
Szabo, Stephen A.....815 W. Chicago Ave.
Teegarden, Joseph A., Jr.....3336 Michigan Ave.
Teegarden, Joseph A.....3336 Michigan Ave.
Vore, Hugh A.....4231 Magoun Ave.
Zallen, Stanley G.....729 W. Chicago Ave.
Zivich, John M.....3701 Main St.

Gary

Alexander, William P. (H)....700 Pennsylvania St.
Almquist, Carl O.....504 Broadway
Anderson, Charles P.....260 Rutledge St.
Anthoulis, George D.....1206 Broadway
Baitinger, Herbert M.....504 Broadway
Baran, Charles.....4380 Jefferson St.
Behn, Walter M.....738 Broadway
Bendler, Carl H.....738 Broadway
Bills, Leroy F.....504 Broadway
Bills, Robert N.....504 Broadway
Boardman, Carl.....504 Broadway
Brady, Samuel G.....765 Broadway
Brown, David B.....504 Broadway
Burcham, James B.....738 Broadway
Carbone, Joseph A.....504 Broadway
Carmody, Raymond F.....504 Broadway
Chevigny, Julius J.....504 Broadway
Comstock, Glenn E.....504 Broadway
Cooper, Leo K.....504 Broadway
Crossland, Steward H.....Methodist Hospital
Cushman, Joseph B.....Methodist Hospital
Danieleski, Ladislaus J.....738 Broadway
DeLong, Charles A.....583 Broadway
Derian, Mardiros H.....765 Broadway
Dian, August J.....729 Broadway
Dian, Julia.....729 Broadway
Dierolf, Edward J.....504 Broadway
Donchess, Joseph C.....215 Broadway
Doty, Flavia M.....858 Broadway
Doty, James R.....504 Broadway
Duncan, John S.....2165 W. 14th St.
Elliott, Ralph A.....504 Broadway
English, Hubert M.....673 Broadway
Franklin, Philip L.....400 Broadway
Galante, Vincent J.....Mercy Hospital
Gannon, George W.....602 Broadway
Geisel, E. E.....583 Broadway
Giorgi, Antonio (H).....243 E. Ridge Rd.
Goldberg, Harold B.....515 Broadway
Goldstone, Adolph.....757 Broadway
Goldstone, Joseph.....757 Broadway
Grant, Benjamin.....1706 Broadway
Gregoline, Amadeo F.....729 Broadway
Gutierrez, Frank A.....504 Broadway
Harris, Byrum W.....738 Broadway
Hinkson, George D.....1606 Broadway
Hodurski, Zigfield.....St. Mary's Hospital
Kahan, Harry L.....738 Broadway
Kendrick, Frank J.....504 Broadway
Knoy, Norris J.....772 Van Buren St.
Kobrak, Heinrich F. G.....336 Grant
Kobrin, Meyer W.....729 Broadway
Kolettis, George J.....860 Broadway
Kopcha, Joseph E.....504 Broadway
Korn, Jerome M.....738 Broadway
Lorenty, Thaddeus B.....738 Broadway
Lovell, Martin H.....1606 Broadway
Lutz, Georgianna.....504 Broadway
McMichael, F. J.....504 Broadway
Majsterek, Stanley L.....1902 W. 11th Ave.
Marcus, Morris C.....738 Broadway
Mather, J. Winford.....3543 Central, East Gary
May, Richard M.....583 Broadway
Minczewski, Richard C.....1400 W. 5th Ave.
Nelson, Walfred A.....559 S. Lake St.
Nesbit, Otis B.....444 Jackson St.
Neuwelt, Frank.....504 Broadway
Palmer, Russell H.....2906 W. 4th Place
Parker, Harry C.....673 Broadway
Parker, John T.....673 Broadway
Parratt, Louis W.....765 Broadway
Puryear, James O.....1606 Broadway
Reynolds, James S.....504 Broadway
Richter, Samuel.....738 Broadway
Rosenbloom, Philip J.....504 Broadway
Rubin, Milton R.....504 Broadway
Rubin, Simon S.....504 Broadway
Ryan, Hubert J.....504 Broadway
Sagel, Jacob.....504 Broadway
Sala, Joseph J.....504 Broadway
Schaible, Ernest L.....738 Broadway
Senese, Thomas J.....504 Broadway
Shellhouse, Michael.....3811 Washington St.
Skeen, Earl D.....504 Broadway
Stimson, Harry R.....504 Broadway
Stoycoff, Christo M.....844 Broadway
Templin, David B.....504 Broadway
Verplank, Grover L.....527 Broadway
Vye, James P.....607 Broadway
Watts, Albert A.....765 Broadway
Weiskopf, Henry S.....504 Broadway
Wharton, Russell O.....673 Broadway
White, William J.....790 Broadway
Wicks, Orlando C. (H).....560 Van Buren
Wimmer, Robert N.....9 W. 6th St.
Yarrington, Charles W.....607 Broadway
Yocum, Paul S.....738 Broadway
Yocum, William S.....738 Broadway
Young, George M.....3776 Broadway
Malmstone, Francis A.....Griffith
Sickierski, Joseph M.....Griffith
Vracin, Daniel J.....Griffith

Hammond

Bethea, Dennis A.....1021 Fields St.
Bolin, John T.....5305 Hohman Ave.
Boswell, Robert W. C.....St. Margaret Hospital
Braginton, Fred.....445 E. State St.
Brown, Stanley L.....6550 Hohman Ave.
Carlo, Joseph F.....5305 Hohman Ave.
Chidlaw, B. W.....5141 Hohman Ave.
Clancy, James F.....5231 Hohman Ave.
Cole, Arthur V.....6827 Kennedy
Cook, George M.....5231 Hohman Ave.
Davis, Alice L.....5016 Hohman Ave.
Detrick, Herbert W.....5231 Hohman Ave.
Eggers, Ernest L.....5141 Hohman Ave.
Eggers, Henry W.....5231 Hohman Ave.
Egnatz, Nicholas.....522 State St.
Eisenberg, David A.....5451½ Hohman Ave.
Elledge, Ray.....5231 Hohman Ave.
Forster, Neslen K.....137 Rimbach St.
Friedman, Isadore E.....5248 Hohman Ave.
Gevirtz, Milton B.....5246 Hohman Ave.
Gardner, H G.....137 Rimbach St.
Groman, Herman C.....137 Rimbach St.
Hack, Edmund C.....5219 Hohman Ave.
Hansen, Arthur H.....5252 Hohman Ave.
Herbst, Robert R.....137 Rimbach Ave.
Hicks, Harry S.....6927 Kennedy Ave.
Hofmann, Andrew.....408 State St.
Hornaday, Walter A.....5252 Hohman Ave.
Howard, William H.....5231 Hohman Ave.
Husted, Robert G.....5248 Hohman Ave.
Jones, Eli S.....5231 Hohman Ave.
Kennedy, Francis D.....5231 Hohman Ave.
Kolanko, Leon A.....6104 Columbia Ave.
Kretsch, Russell W.....5435 Hohman Ave.
Kuhn, Hugh A.....112 Rimbach St.
Kuhn, Hedwig S.....112 Rimbach St.
Lawler, D. H.....21 Wildwood Road
McVey, Clarence A.....5231 Hohman Ave.
Marcus, Emanuel.....5252 Hohman Ave.
Matthews, Charles B.....5404 Hohman Ave.
Modjeski, Raymond J.....5231 Hohman Ave.
Morris, Judson B.....5245 Hohman Ave.
Morrison, Lindsey.....100 Rimbach St.
Nelson, Richard B.....5618 Calumet Ave.
Nodinger, Louis.....540 165th St.
Ostrowski, R. O.....5434 Hohman Ave.
Panares, Solomon V.....5434 Hohman St.
Peck, Edward A.....422 Conkey St.
Pilot, Jean.....5231 Hohman Ave.
Premuda, F. F.....6731 Kennedy Ave.
Rauschenbach, Charles W.....5245 Hohman Ave.
Remich, Antone C.....137 Rimbach St.
Rendel, Donald T.....5231 Hohman Ave.
Rhind, A. W.....5145 Hohman Ave.
Row, Perrie Q.....5231 Hohman Ave.
Rudolph, Franklin G.....5231 Hohman Ave.
Schlesinger, Jacob.....6010 Columbia Ave.
Shanedling, Philip D.....5231 Hohman Ave.
Shanklin, E. M.....5141 Hohman Ave.
Skrentny, Stanley H.....5231 Hohman Ave.
Stern, Samuel L.....5142 Hohman Ave.
Wach, Joseph J.....5252 Hohman Ave.
Dupes, Lowell E.....Hobart
Friedrich, L. M.....Hobart
Kraft, Ralph W.....Hobart
Storer, W. R.....Hobart
Davis, Neal.....Lowell
Mirro, John A.....Lowell
Friedman, Isadore E...237 Highland St., Munster
Rosevear, Henry J.....239 Belden St., Munster

Whiting

Bopp, David W.....1902 Indianapolis Blvd.
Brandman, Harry.....1344 119th St.
Ferry, John.....1900 Indianapolis Blvd.
Frankowski, Clementine E.....1907 New York Ave.
Jones, Clifford M.....1902 Indianapolis Blvd.
Kudele, Louis T.....1321 119th St.
Lauer, Aron J.....1915 Westpark Ave.
McCarthy, Jeremiah A.....1341 E. 119th St.
Rudser, Donald H.....1902 Indianapolis Blvd.
Silvian, Harry A.....1400 119th St.
Smith, Theodore J.....1902 Indianapolis Blvd.
Stecy, Peter.....1902 Indianapolis Blvd.
Wisch, Lewis J.....1346 119th St.
Brody, Arthur.....Los Angeles, Calif.
Bullard, Mattie J.....Casselton, N. D.
Diamondstein, Joseph.....796 State Line St. Calumet City, Ill.
Holmes, George W.....340 W. Barry Ave., Chicago, Ill.
Kammer, Adolph G.....42 Broadway (Rm. 537), New York, New York
LaFata, Francis P.....Springfield, Ill.
Modjeski, Joseph R.....652 Wentworth Ave., Calumet City, Ill.
Morris, Judson B.....Boise, Idaho
Russo, John G.....Kaukauna, Wis.
Shanklin, James G.....Fort Steilacoom, Wash.
Smith, Louis D.....3904 E. 92nd St., Chicago, Ill.
Tyrrell, Thomas C.....734 Wentworth Ave., Calumet City, Ill.
Van Dorf, Nathaniel.....1238 S. Harding St., Chicago, Ill.
Jackman, Abraham J.....Address unknown
Moss, Harlan B.....Address unknown
Teplinsky, Louis H.....Address unknown

LA GRANGE COUNTY

Wade, Alfred A.....Howe
Erwin, Harry G.....LaGrange
Flannigan, Harley F.....LaGrange
Schulz, Clarence H.....LaGrange
Hildebrand, William O.....Topeka

LA PORTE COUNTY

Oak, David D.....LaCrosse

La Porte

Danruther, Charles B.....907 Maple Ave.
Fargher, Robert A.....811 Jefferson Ave.
Farnsworth, Samuel A.....702 Lincoln Way
Fischer, Carlton N.....1001 Maple Ave.
Jones, Robert B.....808 Michigan Ave.
Kelly, Jon N.....704 Jefferson Ave.
Kelsey, Robert M.....702 Maple Ave.
Kepler, Robert W.....713 Maple
Larson, G. O.....809 Jefferson St.
Linn, Elbert E.....809 Jefferson St.
Martin, William B.....812 Michigan Ave.
Morgan, Samuel P.....820 Michigan Ave.
Muhleman, C. E.....1209 Michigan Ave.
Przednowek, Adolph C.....909 Madison St.
Ross, Wilbur W.....P. O. Box 102
Simon, Arthur R.....806 Maple Ave.
Wilcox, Robert F.....808 Maple Ave.

Michigan City

Armstrong, Thomas D.....113 E. Ninth St.
Bailey, A. L.....Warren Clinic
Baker, Warren.....516 East Coolspring Ave.
Bankoff, Milton L.....125 E. Fifth St.
Bernoske, Daniel G.....731 Pine St.
Brooks, Harry L.....125 E. Fifth St.
Burris, Floyd L.....731 Spring St.
Donovan, Stephen J.....702 Pine St.

LA PORTE COUNTY—(Cont.)

Michigan City

Fargher, Francis M.....723 Franklin St.
Feerer, Donald 117 W. Seventh St.
Gardner, Melvin D.....916 Washington St.
Gilmore, Russell A.....801 Washington St.
Kemp, John T.....916 Washington St.
Kennington, Dillon J.....309 E. Tenth St.
Kerrigan, John J. (H).....913 Washington St.
Kerrigan, Robert L. 916 Washington St.
Killough, Aimee R.....731 Washington St.
Kubik, Francis J.....201 E. Eighth St.
Piazza, Leonard F.....404 Warren Bldg.
Reed, Ann M.....125 E. Fifth St.
Reed, Nelle 501 Spring St.
Robrock, Lawrence M.....315 Warren Bldg.
Snodgrass, Milo R.....Warren Clinic
Spinning, A. L. (H).....130 Superior St.
Stephenson, Lewis E.....901 Washington St.
Straus, David C.....125 E. Fifth St.
Warren, Frank R.....723 Franklin St.
Weeks, Patrick H.....Box 41
Wilson, Leroy A.....125 E. Fifth St.
Walkinshaw, William (H).....Stillwell
Moosey, Louis Union Mills
Benz, Owen Wanatah

LAWRENCE COUNTY

Bedford

Allen, Loniel H.....307 Citizens Nat. Bank Bldg.
Austin, Richard P....209 Citizens Nat. Bank Bldg.
Bridwell, Edgar.....1317 L St.
Byers, Norman R.....Citizens Nat. Bank Bldg.
Dusard, Joseph C.....305 Citizens Nat. Bank Bldg.
Emery, Charles B.....1027 15th St.
Emery, Charles H. (H).....1027 15th St.
Martin, Frank D.....1501 I St.
Newland, Arthur E.....1112 15th St.
Pearson, John B.....1501½ J St.
Ragsdale, Harrison C.....Citizens Nat. Bank Bldg.
Robertson, Moorman O....Citizens Nat. Bank Bldg.
Scherschel, John P.....1713 H St.
Smallwood, Robert B.....Masonic Temple
Speheger, Benjamin A.....400 Citizens Bank Bldg.
Stone, Charles E.....VonRitz Theatre Bldg.
Wohlfeld, Julius B.....1124 16th St.
Wynne, Roland E.....1009½ W. 15th St.
Gill, Bernard P.....Mitchell
Hamilton, James R.....Mitchell
Rohner, Ralph G.....Mitchell
Dollens, Claude Oolitic
Simpson, Morrell E.....3026 Second Ave., N., St. Petersburg, Fla.
Cohen, Morris Loulsville, Ky.

MADISON COUNTY

Carpenter, John L.....Alexandria
Gaunt, Everett W.....Alexandria
Gibson, John J.....Alexandria
Keller, Frank G. (H).....Alexandria
Otto, Anthony E. (H).....Alexandria
Overpeck, George H.....Alexandria

Anderson

Aagesen, Walter J.....Citizens Bank Bldg.
Armington, Charles L. 655 Citizens Bank Bldg.
Armington, John C.....206 E. 14th St.
Armington, Robert L.....315 Citizens Bank Bldg.
Austin, Maynard A.....238 W. 12th St.
Ayres, Kenneth D.....704 Anderson Bank Bldg.
Brauchla, Carl H.....117 W. 17th St.
Brock, Earl E.....931 Meridian St.
Charles, Etta (H).....504 W. 11th St.
Conrad, Ernest M.....931 Meridian St.
Dixon, Rex W.....934 W. 8th St.
Doenges, James L.....301 Citizens Bank Bldg.
Drake, John C.....604 Anderson Bank Bldg.
Ellis, Seth W.....335 W. 5th St.
Elsten, Aubrey W.....704 Anderson Bank Bldg.
Erehart, Archie D.....931 Meridian St.
Gante, Henry W.....619 Citizens Bank Bldg.
Guthrie, Francis C.....412 Anderson Bank Bldg.
Hart, William D.....Citizens Bank Bldg.
Hensler, Benton M.....2920 Jefferson St.
Jarrett, Paul E.....331 Citizens Bank Bldg.
Jones, Horace E.....1110 Meridian St.
Kelly, Wendell C.....704 E. 8th St.
King, Bernard A.....1110 N. Meridian St.
King, Joseph W.....1110 N. Meridian St.
Kopp, Otis A.....1110 N. Meridian St.
Lamey, James L Citizens Bank Bldg.
Lamey, Paul T.....423 Citizens Bank Bldg.
Larmore, Joseph L.....117 W. 13th St.
Litzenberger, Sam W.....622 Citizens Bank Bldg.
Long, James A. (H).....1110 Meridian St.
Long, Paul L.....710 Anderson Bank Bldg.
McDonald, Vergil G.....1110 Meridian St.
McFall, Voris.....2210 Meridian St.
Meister, Doris.....Citizens Bank Bldg.
Metcalf, George B.....931 Meridian St.
Nelson, Paul L.....717 Anderson Bank Bldg.
Nesbit, Leonard L.....415 Citizens Bank Bldg.
Patterson, William K.....St. John's Hospital
Quickel, Daniel S. (H).....1012 Meridian St.
Reed, Roger R.....232 W. 12th St.
Rosenbaum, Lloyd E.....647 Citizens Bank Bldg.
Ross, Guy E.....1110 Meridian St.
Rozelle, Clarence V.....611 Citizens Bank Bldg.
Sharp, William L.....449 Citizens Bank Bldg.
Stamper, Joseph Anderson
Swan, Richard C.....Delco Remy
Tracy, Julius R 738 W. 8th St.
Wilder, Gordon B.....931 Meridian St.
Wilkinson, Roger L.....619 Citizens Bank Bldg.
Willson, Canby L.....2003 Meridian St.
Wishard, Frederick B.....2401 Columbus Ave.
Wright, Cecil S.....523 City Bank Bldg.
York, Arthur F.....Citizens Bank Bldg.
Zicrer, Reuben O.....931 Meridian St.
Cotton, Perry Elwood
Fitzpatrick, Harry W.....Elwood
Hanson, Martin F.....Elwood
Hoppenrath, Wesley M. Elwood
Hoppenrath, William H. (H).....Elwood
Laudeman, Walter A.....Elwood
Ploughe, Monroe L. (H).....Elwood
Ploughe, Ralph R. Elwood
Russell, O. Raymond.....Frankton
Rinne, John J.....Lapel
Jones, Albert T.....Pendleton
McLaughlin, Calvin P.....Pendleton
McVaugh, Charles C.....Pendleton
Sisson, Helen M.....Pendleton
Williams, Francis M., Jr.....Pendleton
Irwin, Seth Summitville
VanNess, William C.....Summitville
Williams, Robert H.....Franklin Square Hospital, Baltimore, Md.

MARION COUNTY

Butler, Raymond A.....902 Main St., Beech Grove
Kim, Young D.....136 N. 17th St., Beech Grove
Ramage, Walter F...244 S. First St., Beech Grove
Rhea, James C.....801 Main St., Beech Grove
Wade, Fred L.....Bridgeport

Indianapolis

Adkins, Harold C.....409 E. 30th St. (5)
Adkins, Onan C.....2817 Clifton St. (8)
Albertson, Frank P....5304 W. Washington St. (8)
Albright, Victor F.....I. U. Medical Center (7)
Alburger, Henry R....504 Hume Mansur Bldg. (4)
Aldrich, Harry D....401 Hume Mansur Bldg. (4)
Aldrich, Howard.....4316 E. Washington St. (1)
Alvis, Edmond Ochs..320 Hume Mansur Bldg. (4)
Anderson, Ralph J.....718 Hume Mansur Bldg. (4)
Appel, Richard H.....603 Hume Mansur Bldg. (4)
Arbogast, J. L.....I. U. Medical Center (7)
Arbuckle, Russell L...615 Hume Mansur Bldg. (4)
Arbuckle, William E.....1156 Lee St. (3)
Arnold, Aaron Leon.....607 E. Maple Rd. (5)
Aronson, Sidney S.....618 Hume Mansur Bldg. (4)
Austin, Eugene W.....I. U. Medical Center (7)
Baehmann, Arnold J.....149 W. 20th St. (2)
Bahr, Max Augustus....Central State Hospital (8)
Baker, Leslie M.....1825 Christopher Lane (8)
Bakemeier, Otto H....5503 E. Washington St. (1)
Baleh, James F.....709 Hume Mansur Bldg. (4)
Ball, Joseph Emory.....5039 E. Tenth St. (1)
Banister, Revel F.....2958 Central Ave. (5)
Banks, Horace M.....Methodist Hospital (7)
Barnett, Ernest R.....City Hospital (7)
Barry, Mauriee J.....55-56 Bar Ass'n. Bldg. (4)
Bartle, James L.....R. R. 12, Box 117A
Bartley, Max D.....1215 N. Penn. St. (2)
Batman, Gordon W....723 Hume Mansur Bldg. (4)
Battersby, J. Stanley....I. U. Medical Center (7)
Bauer, Thomas B.....1015 Hume Mansur Bldg. (4)
Beaeh, Robert R.....2630 E. 10th St. (1)
Beams, Ralph.....I. U. Medical Center (7)
Beasley, Thomas J.....428 Bankers Trust Bldg. (4)
Beatty, Norman M....725 Hume Mansur Bldg. (4)
Beaver, Howard W.....11 E. Raymond St. (2)
Beck, Evart Malcolm....I. U. Medical Center (7)
Beckman, Henry F....514 Hume Mansur Bldg. (4)
Beeler, John Watson.....4551 Park Ave. (5)
Beeler, Raymond C....712 Hume Mansur Bldg. (4)
Belden, Louis D.....624 Hume Mansur Bldg. (4)
Berger, Henry l.....3665 Watson Rd. (5)
Berman, Jacob K.....906 Hume Mansur Bldg. (4)
Beverland, Malon E....3036 E. Washington St. (1)
Bibler, Lester D.....811 Underwriters Bldg. (4)
Bird, Charles R.....301 Hume Mansur Bldg. (4)
Blackford, Florence.....2605 Shelby St. (3)
Blaekford, Ralph.....503 Hume Mansur Bldg. (4)
Blackford, Roger W....503 Hume Mansur Bldg. (4)
Blatt, A. Ebner.....3450 Winthrop Ave. (5)
Bloemker, Edward F.....2660 Shelby St. (3)
Boaz, John J.....302 Ind. Pythian Bldg. (4)
Boggs, Eugene F.....4104 Madison Ave. (3)
Bohner, Caryle B.....822 Hume Mansur Bldg. (4)
Bond, George S.....1221 N. Delaware St. (2)
Booher, Norman R.....447 E. Maple Rd. (5)
Booher, Olga Bonke.....447 E. Maple Road (5)
Bowers, Don D.....711 Underwriters Bldg. (4)
Bowman, George W....1098 W. Michigan St. (7)
Bown, Albert J.....3752 N. Euclid (1)
Boyd, David A...I. U. Med. Center & City Hospital
Boyer, Edward Beck.....Sunnyside Sanatorium, R. R. No. 12 (44)
Boyer, Floyd A.....442 N. Drexel Ave. (1)
Boys, Floyd.....606 Bankers Trust Bldg. (4)
Brady, Thomas A.....440 Berkley Rd. (8)
Brayton, John R....445 N. Penn St., No. 704 (4)
Brayton, Lee.....3342 N. Illinois St. (8)
Brodie, Donald W.....817 C. of C. Bldg. (4)
Brother, George M.....State Board of Health, 1098 W. Michigan St. (7)
Brown, Archie E.....1220 S. Belmont Ave. (3)
Brown, David E.....520 Hume Mansur Bldg. (4)
Brown, DeWitt W.....City Hospital (7)
Brown, Edward A....201 Ftn. Sq. Th. Bldg. (3)
Brown, Frances T.....2126 N. Talbot St. (2)
Brown, Harry M.....City Hospital (7)
Brown, Leland, G City Hospital (7)
Brown, Wendell E....806 Chamber of Comm. Bldg.
Browning, James S.....3209 N. Meridian (8)
Browning, William M.....City Hospital (7)
Brubaker, Elmer H.....624 E. 23rd St. (5)
Bruetseh, Walter L....Central State Hospital (8)
Bryan, Franklin A.....City Hospital (7)
Buehl, Robert Fred.....1906 S. Meridian St. (2)
Bundy, Chester M.....State Board of Health (7)
Burdette, Harold F.....Methodist Hospital (7)
Burney, Leroy E.....1098 W. Michigan St. (7)
Buttz, Rose J. P.....Indiana K. of P. Bldg. (4)
Cahal, Ernest E.....2614 Shelby St. (3)
Cahn, Hugo M.....506 E. 30th St. (5)
Call, Herbert F.....321 Hume Mansur Bldg. (4)
Calvy, William J.....224 N. Meridian St. (4)
Campbell, John A I. U. School of Medicine (7)
Campbell, Sam W.....2035 N. Meridian St. (2)
Canady, James W.....1229 Prospect St. (3)
Caplin, Irvin.....2033 N. Harding St. (2)
Caplin, Samuel S.....111 E. 30th St. (5)
Carson, Wayne.....601 Hume Mansur Bldg. (4)
Carter, James C.....502 Hume Mansur Bldg. (4)
Carter, Oren E.....668 E. 38th St. (5)
Caseley, Donald J....508 Hume Mansur Bldg. (4)
Chen, Ko Kuei.....Eli Lilly & Company (6)
Clark, C. P.....922 Hume Mansur Bldg. (4)
Clark, Cyrus J.....6325 Guilford Ave. (5)
Clark, Lawson J....420 Hume Mansur Bldg. (4)
Clevinger, William G.....1839 Ellen Dr. (8)
Close, Walter D....809 Hume Mansur Bldg. (4)
Clouse, Paul A.....City Hospital (7)
Coble, Ralph R.....3769 College Ave. (5)
Cohen, Bernard W.....1043 N. Pennsylvania (7)
Colglazier, Donald L..908 Hume Mansur Bldg. (4)
Collins, Hubert L.....975 N. Emerson Ave. (1)
Collins, James N.....712 Hume Mansur Bldg. (4)
Conger, Elizabeth S...310 Ind. K. of P. Bldg. (4)
Conley, Joseph Leo....2243 E. Washington St. (1)
Conway, Chester C....4305 E. Michigan St. (1)

MARION COUNTY—(Cont.)

Indianapolis

Conway, Glenn.....1620 S. East St. (2)
Cook, Charles Jacob.....244 N. Noble St. (2)
Copeland, Samuel J...427 Bankers Trust Bldg. (4)
Cornacchione, Matthew.....814 S. East St. (2)
Cortese, Thomas A.....435 S. East St. (4)
Cottingham, Chas. E....3641 N. Pennsylvania (5)
Cox, Clifford Earl.....720 Underwriters Bldg. (4)
Cox, Harold Bailey....5316 E. Washington St. (1)
Craft, Kenneth L.....1002 Hume Mansur Bldg. (4)
Crawford, John A.....920 E. 40th St. (5)
Culbertson, Clyde G.....Eli Lilly & Co. (6)
Cullen, Paul Kent....422 Hume Mansur Bldg. (4)
Cunningham, John M...508 Hume Mansur Bldg. (4)
Cuthbert, Marvin.....619 Hume Mansur Bldg. (4)
Dalton, John Eric.707-708 Hume Mansur Bldg. (4)
Daniel, John Carlton.1008 Hume Mansur Bldg. (4)
Davidson, Noble C.....3008 Clifton St. (8)
Davis, James M.....Address Unknown
Davis, John A.....2719 E. Michigan (1)
Davis, Sam J.....3266 Winthrop (5)
Day, Clark William...611 Bankers Trust Bldg. (4)
Day, John Thomas.....709 Underwriters Bldg. (4)
DeArmond, Albert M..723 Hume Mansur Bldg. (4)
Dean, Michael F.....235 E. 11th St. (2)
Dearmin, Robert M.....3440 N. Meridian St. (8)
Deer, Blan Forsythe..707 Bankers Trust Bldg. (4)
Deever, John Wilkin.....4131 Shelby St. (3)
Demotte, C. Bowen.....808 C. of C. Bldg. (4)
Denny, Forrest L.....2724 W. Tenth St. (8)
Denny, James W.....5504 E. Washington St. (1)
Des Jean, Paul A.....316 Pennway Bldg. (4)
Dewees, Dwight L.....302 N. Bradley St. (1)
Dieter, William J.....2015 S. Penn. St. (2)
Dilts, Robert Louis.....4604 E. 10th St. (1)
Dimond, Edmunds G.....39 E. Ninth St. (4)
Donato, Albert M.....1521 Shelby St. (3)
Dorman, Jack.....760 Bankers Trust (4)
Dorman, Willis L.....5508 E. Washington St. (1)
Dowd, Joseph A.....35 E. 56th St. (5)
Dugan, Thomas J.....2540 W. Washington St. (8)
Dugan, William M.....410 Hume Mansur Bldg. (4)
Dulin, Basil Burton.....City Hospital (7)
Dunlap, Harold F.....723 Hume Mansur Bldg. (4)
Dunbar, Colin V.....424 Hume Mansur Bldg. (4)
Dunning, Lehman M.....1561 College Ave. (2)
Dyar, Edwin W., Jr....706 Hume Mansur Bldg. (4)
Dyer, Wallace K.....City Hospital (7)
Eastman, Joseph R.....970 N. Meridian St. (4)
Eaton, Edwin R.....Methodist Hospital (7)
Ebert, John Wayne.....509 Lincoln St. (3)
Eberwein, John H.....720 Hume Mansur Bldg. (4)
Egbert, Herbert L....822 Hume Mansur Bldg. (4)
Egbert, Roy.....2601 Roosevelt Ave. (1)
Eikenberry, H. W.....616 Bankers Trust Bldg. (4)
Eldridge, Gail E.....4559 Marcy Lane (5)
Ellis, Bert Edward....303 Hume Mansur Bldg. (4)
Emhardt, John Thilo.....1621 S. East St. (2)
Emhardt, John Wm...Emhardt Memorial Hospital, 512 E. Minnesota St. (3)
Ensminger, L. A.....908 Hume Mansur Bldg. (4)
Enzor, Ora K.....4216 College Ave. (5)
Ernst, Clifford E.....2611 W. Michigan St. (8)
Evans, Paul Vincent.....City Hospital (7)
Everly, Ralph V.....4216 College Ave. (5)
Farrell, Joseph T.....2807 E. Michigan (1)
Fausset, C. Basil.....408 Hume Mansur Bldg. (4)
Ferguson, William B.....I. U. Medical Center (7)
Fisch, Charles....Vet. Administration Hosp. (44)
Fisk, Frank Byron.....1200 Madison Ave. (6)
Fitzgerald, William J.....326 K. of P. Bldg. (4)
Flanigan, Meredith B.....Methodist Hospital (7)
Flick, John J.....1441 N. Pennsylvania (2)
Flora, Joseph Oren..4317 W. Washington St. (8)
Folkening, Norval C..313 Ft. Sq. Theatre Bldg. (3)
Foreman, Harry Lee.....60 W. 30th St. (8)
Forry, Frank..I. U. M. C., 1040 W. Michigan (7)
Fosler, David W.....415 Underwriters Bldg. (4)
Fouts, Paul J.....522 Hume Mansur Bldg. (4)
Franklin, Ernest J.....711 E. 54th St. (5)
Fromhold, Willis A.....743 S. East St. (2)
Fry, Robert D.....612 Hume Mansur Bldg. (4)
Fullerton, Robert L.....3746 N. Illinois St. (8)
Funkhouser, A. G.....702 Underwriters Bldg. (4)
Funkhouser, Elmer....702 Underwriters Bldg. (4)
Furgason, Paul C....1008 Hume Mansur Bldg. (4)
Furniss, Sumner A.....401 Indiana Ave. (2)
Gabe, Harry Edwin.....502 W. Hampton Dr. (8)
Gabe, William E....612 Hume Mansur Bldg. (4)
Gaddy, Euclid Taylor..2602 W. Washington St. (8)
Gallup, Palmer R.....601 Inland Bldg. (4)
Gambill, William D....408 Hume Mansur Bldg. (4)
Garber, J. Neill....1024 Hume Mansur Bldg. (4)
Garceau, George J....508 Hume Mansur Bldg. (4)
Gardiner, Sprague H...202 Hume Mansur Bldg. (4)
Gardner, Buckman.....134 E. 22nd (2)
Garfield, Martin D.....Veterans Hospital, Cold Springs Road (44)
Garner, William.....2911 E. Tenth St. (1)
Garner, W. Stanley.....2911 E. Tenth St. (1)
Garrett, John D.....57 Bar Assn. Bldg. (4)
Gastineau, Frank M...407 Hume Mansur Bldg. (4)
Gatch, Willis D....605 Hume Mansur Bldg. (4)
Gauss, Julius H. P.....502 Blue Ridge Rd. (8)
Geider, Roy A.....1443 Prospect St. (3)
George, Charles L., Jr.....507 E. 34th St. (5)
Gick, Herman H.....2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
2129 E. Michigan St. (1)
Gillespie, Charles F.....3209 N. Meridian (8)
Gillespie, Jacob E.....523 Hume Mansur Bldg. (4)
Glass, Robert Lee....608 Hume Mansur Bldg. (4)
Glendening, John L.....132 Insurance Bldg. (4)
Godersky, Lois G.....3315 N. Euclid Ave. (1)
Goldman, Samuel.....2902 Central Ave. (5)
Goodrich, Albert.....3101 Washington Blvd. (5)
Goodwin, Caroline M.....307 N. Penn. St. (4)
Gosman, James H.....City Hospital (7)
Goss, Herschel W.....4016 E. Michigan St. (1)
Gramling, Joseph J.....3326 Clifton St. (8)
Graves, John W.....4734 E. 10th St. (1)
Greist, John H.....202 Hume Mansur Bldg. (4)
Griffith, Ross Earl....915 Hume Mansur Bldg. (4)
Grisell, Ted Lewis.....City Hospital (7)
Griswold, Waite R.....5830 University Ave. (1)
Gustafson, Gerald W...314 Hume Mansur Bldg. (4)
Gutelius, Charles B....900 Underwriters Bldg. (4)
Habich, Carl.....702 Hume Mansur Bldg. (4)
Hadden, Claude E....424 Hume Mansur Bldg. (4)
Hadley, Alfred W.....4506 Gadsen St. (3)
Hadley, David Riley Hospital (7)
Hadley, Murray N.....809 Hume Mansur Bldg. (4)
Haggard, Edmund B...806 Bd. of Trade Bldg. (4)
Hahn, E. Vernon....914 Hume Mansur Bldg. (4)
Hall, Frank McKinley..300 Bd. of Trade Bldg. (4)
Hall, Jack R.....3342 N. Illinois (8)
Hallam, Franklin T.....P. O. Box 406 (6)
Hamer, Homer G.....1711 N. Capitol Ave. (7)
Hamilton, Howard B...3837 N. New Jersey St. (5)
Hampshire, Donald R.....1443 N. Penn. St. (2)
Hancock, John G.....2226 W. Michigan St. (8)
Hansell, Robert M 1320 N. Delaware St. (2)
Harden, Murray E.....3557 N. Sherman Dr. (1)
Harcourt, Allan K.....812 C. of C. Bldg. (4)
Harding, Myron S.....308 Hume Mansur Bldg. (4)
Hare, Earl Hazelton.....Veterans' Hospital (44)
Hare, Laura 404 Hume Mansur Bldg. (4)
Harold, Albert H.....502 Bankers Trust Bldg. (4)
Harold, Norris E.....434 Bankers Trust Bldg. (4)
Harris, Carl B.....319 Hume Mansur Bldg. (4)
Harris, Paul Noel.....Eli Lilly & Co. (6)
Haskell, Cosa Dell.....141 S. Meridian St. (4)
Haslinger, C. J.....2151 E. New York St. (1)
Hatfield, B. F.....806 C. of C. Bldg. (4)
Hatfield, N. W.....2032 N. Rural St. (1)
Hawk, James H.....514 Hume Mansur Bldg. (4)
Hays, Everett L.....2634 Manker Ave. (3)
Heinrichs, Harry H....705 Bankers Trust Bldg. (4)
Heinz, Dorothy C. V.....5435 Carrollton Ave. (5)
Hendricks, John DeW....2230 N. Delaware St. (5)
Hendricks, John W....911 Hume Mansur Bldg. (4)
Hennessee, Philip C.....City Hospital (7)
Henry, Russell S...1019 Hume Mansur Bldg. (4)
Hepburn, Charles K...524 Hume Mansur Bldg. (4)
Hetherington, A. M.....4121 E. New York St. (1)
Hetherington, John A.....Methodist Hospital (7)
Heubi, John Edward.....668 E. Maple Rd. (5)
Hewitt, John H.....1104 Roosevelt Bldg. (4)
Hickman, Walter F.....1210 Oliver Ave. (3)
Hill, Kenneth A.....2120 N. Meridian St. (2)
Himler, James M.....809 Underwriters Bldg. (4)
Hine, Ulis B.....4808 E. Michigan St. (1)
Hines, Don Carlos.....Eli Lilly & Co. (6)
Hippensteel, Russell R.....3749 Central Ave. (5)
Hodges, Fletcher.....3160 N. Pennsylvania (5)
Hofmann, John W.....323 Hume Mansur Bldg. (4)
Holman, J. E., Sr....523 Bankers Trust Bldg. (4)
3315 E. 10th St. (1)
Holman, J. E., Jr.....3315 E. 10th St. (1)
Hood, Ainslee A.....1435 W. 26th St. (8)
Howell, Joseph D.....City Hospital (7)
Howell, Robert D.....900 Underwriters Bldg. (4)
Horsman, Russell K.....Veterans Hospital (44)
Hoyt, Lester H.....Methodist Hospital (7)
Huber, Carl Parker.....I. U. Medical Center (7)
Hudson, Foster J.....3440 N. Meridian St. (8)
Hughes, James E.....1126 S. Meridian St. (2)
Hughes, William F....401 Hume Mansur Bldg. (4)
Hurt, Laverne B.....635 E. 59th St. (5)
Hurt, Paul Thomas.....4151 N. Penn. (5)
Huse, William M.....3310 N. Meridian St. (8)
Hynes, Roy T.....938½ E. 30th St. (5)
Iske, Paul G.....1015 Hume Mansur Bldg. (4)
Jackson, Frederick E.....57 Bar Ass'n Bldg. (4)
Jackson, James W.....State Board of Health (7)
Jackson, Jesse Lee.....3001 E. Tenth St. (1)
Jacobs, Harry Aaron..332 Bankers Trust Bldg. (4)
Jaeger, Alfred S.....2935 Washington Blvd. (5)
Jaquith, Orville S.....261 Blue Ridge Rd.
Jay, Arthur N.....3005 N. Illinois St. (8)
Jefferies, Kenneth I.....807 Virginia Ave. (3)
Jennings, Frank L....Sunnyside Sanatorium (44)
Jewett, Joe H.....4907 Rosslyn Ave. (5)
Jewett, Robert E.....State Board of Health (7)
Jinks, Clifford H.....4216 College Ave. (5)
Jobes, James E....305 Traction Terminal Bldg. (4)
Jobes, Norman E..305 Traction Terminal Bldg. (4)
Johnson, Lowell R.....Methodist Hospital (7)
Johnson, Thomas W...529 Bankers Trust Bldg. (4)
Johnson, William F....2121 N. Harding St. (2)
Jones, David E.....828 C. of C. Bldg. (4)
Jones, Francis P.....4305 E. Michigan St. (1)
Joseph, Herbert L.....2715 S. Fleming St. (3)
Joseph, Rex M.....1621 S. East St. (2)
Kabel, Robert N.....912 E. 46th St. (5)
Kahler, Maurice V.....2338 W. Michigan St. (8)
Kahn, Alexander J.....3156 Washington Blvd. (5)
Kalb, Everett L.....1902 E. 38th St. (1)
Kammen, Leo.....3414 Clifton St. (8)
Kauffman, Sidney A...226 Hume Mansur Bldg. (4)
Keenan, Reid L.....812 C. of C. Bldg. (4)
Keever, Charles H.....5214 College Ave. (5)
Keiser, Venice D.....646 Bankers Trust Bldg. (4)
Kelly, Don E.....702 Underwriters Bldg. (4)
Kelly, John F.....517 Hume Mansur Bldg. (4)
Kelly, Walter F.....5503 E. Washington St. (1)
Kelly, William M.....2258 N. Meridian St. (8)
Kempf, Gerald F.....307 City Hall (4)
Kendrick, William M.....4602 Norwaldo (5)
Kennedy, Hunter F.....1105 Prospect (3)
Kerr, Harry R.....2817 E. Washington St. (1)
Ketcham, Jane M.....514 Hume Mansur Bldg. (4)
Kilgore, Byron, Jr.....423 W. 42nd St.
Kime, Charles E.....I. U. Medical Center (7)
King, William E.....811 Hume Mansur Bldg. (4)
Kingsbury, John K....5462 E. Washington St. (1)
Kirch, Leo N.....City Hospital (7)
Kiser, Edgar F.....226 Hume Mansur Bldg. (4)
Kitterman, Harry E...510 Hume Mansur Bldg. (4)
Klain, Benjamin V.....4157 College Ave. (5)
Klaus, Julius M.....Veterans Hospital (44)
Kohlstaedt, Geo. W...422 Hume Mansur Bldg. (4)
Kohlstaedt, Karl C...422 Hume Mansur Bldg. (4)
Kohlstaedt, K. G.....City Hospital (7)
Koons, Karl M.....922 Hume Mansur Bldg. (4)
Kopp, Herschel S.....4625 E. 10th St. (1)
Kornafel, L. H.....608 K. of P. Bldg. (4)
Kraft, Bennett.....760 Bankers Trust Bldg. (4)
Kuntz, Herman W....501 Hume Mansur Bldg. (4)
Kurtz, Fred Baldwin..315 Bankers Trust Bldg. (4)
Kurtz, Philip L.....668 E. 38th St., No. 4 (5)
Kwitny, I. J.....3209 N. Meridian St. (8)
LaDine, Clarence B.....4221 E. 35th St. (1)
Lamb, Emmett B.....205 Hume Mansur Bldg. (4)
Lamb, Russell W.....205 Hume Mansur Bldg. (4)
Lamber, Chet K.....912 Hume Mansur Bldg. (4)
Lambert, C. W.....7725 College Ave. (44)
Langdon, Harry K.....3264 N. Pennsylvania (5)
Laramore, Ward.....3133 Ruckle (5)
Larkin, Bernard J.....305 Hume Mansur Bldg. (4)
Lawler, George F.....3934 E. 10th St. (1)
Leasure, J. Kent.....611 Hume Mansur Bldg. (4)
Leatherman, H. L.....1531 Broadway (2)
LeClaire, Henri.....214 Hume Mansur Bldg. (4)
Leff, Abe H.....712 E. 52nd St. (5)
Leffel, James M., Jr.....3209 N. Meridian (8)
Lemmon, Brandt E.....1105 Prospect (3)
Leonard, Henry S....303 Hume Mansur Bldg. (4)
Leser, Ralph U.....424 Hume Mansur Bldg. (4)
Levi, Leon.....40 W. 38th St. (8)

MARION COUNTY—(Cont.)

Indianapolis

Lewis, James R.....808 Fletcher Ave. (3)
Libbert, Edwin L.....6009 Washington Blvd. (5)
Lichtenberg, Melvin.....3650 College Ave. (5)
Lidikay, Edward C....621 Hume Mansur Bldg. (4)
Lindenmuth, E. O.....623 N. Penn. St. (4)
Lingeman, Edward L...315 Hume Mansur Bldg. (4)
Link, Goethe.....608 Ind. Pythian Bldg. (4)
Littell, J. Jerome....603 Hume Mansur Bldg. (4)
Little, John W.....2735 E. 10th St. (1)
Little, John W., Jr.....I. U. Medical Center (7)
Lochry, Ralph L.....St. Vincent's Hospital (4)
Loehr, William M.....712 Hume Mansur Bldg. (4)
Lomax, Claude C.....2017 E. 52nd St. (5)
Long, William Hunt.....730 W. 30th St. (8)
Loomis, Norman S....804 Hume Mansur Bldg. (4)
Lord, Glenn C.....104 E. Maple Rd. (5)
Loudermilk, Jack L.....I. U. Medical Center (7)
Ludwig, Oscar D.....5433 Madison Ave. (3)
Lukenbill, Emery B.....661 E. 49th St. (5)
Lybrook, William B.....3749 N. Keystone Ave. (1)
MacDonald, John A....408 Hume Mansur Bldg. (4)
MacGregor, D. E.....130 E. Washington, No. 501 (4)
McBride, James S.....810 Hume Mansur Bldg. (4)
McCallum, J. T. C.....237 W. 46th St. (8)
McCaskey, Carl H.....608 Guaranty Bldg. (4)
McCormick, C. O.....621 Hume Mansur Bldg. (4)
McCormick, C. O., Jr..621 Hume Mansur Bldg. (1)
McCown, P. E.....521 Hume Mansur Bldg. (4)
McCulloch, C. B.....1135 State Life Bldg. (6)
McDevitt, Daniel R.....4141 College Ave. (5)
McIntyre, Charles J...414 Hume Mansur Bldg. (4)
McIntyre, James M...806 Hume Mansur Bldg. (4)
McKinley, A. David..Ind. University Hospitals (7)
McKinstray, H. R....737 Underwriters Bldg. (4)
445 N. Pennsylvania St. (4)
McMillan, Frederick G..1410 Odd Fellow Bldg. (4)
McNaull, Charles Hotel English (4)
McQuiston, Ralph J.....608 Guaranty Bldg. (4)
McTurnan, Robert W.....2130 W. 46th St. (5)
Machlan, Harold F.....Address Unknown
Mader, John H...Vet. Hosp., Cold Springs Rd. (44)
Magennis, Herbert L..4681/2 W. Washington St. (4)
Maly, Charles H.....205 Hume Mansur Bldg. (4)
Manion, Marlow W....604 Hume Mansur Bldg. (4)
Mann, Mortimer.....323 Hume Mansur Bldg. (4)
Marshall, Albert L., Jr...3465 Carrollton Ave. (5)
Marshall, Augustus L..518 Hume Mansur Bldg. (4)
Marshall, Cavins R.....1539 N. Illinois St. (2)
Martin, Hugh E.....1200 Madison Ave. (2)
Martin, Loren H....2602 W. Washington St. (8)
Martz, Carl D.....508 Hume Mansur Bldg. (4)
Masters, John B.....Veterans Hospital (44)
Masters, John M.....805 Hume Mansur Bldg. (4)
Masters, Robert J.....805 Hume Mansur Bldg. (4)
Matthew, W. Burleigh.520 Hume Mansur Bldg. (4)
Matthews, Bernard J.....4612 E. 10th St. (1)
Megenhardt, D. S...1015 Hume Mansur Bldg. (4)
Meiks, Lyman T.....Riley Hospital (7)
Melloh, Ardis F.....2821 E. Tenth St. (1)
Mendenhall, C. D....4592 E. Washington St. (1)
Mendenhall, W. E.....515 N. Rural St. (1)
Mentendiek, M. H.....205 Hume Mansur Bldg. (4)
Mericle, Earl W.....817 Hume Mansur Bldg. (4)
Merrell, Paul.....914 Hume Mansur Bldg. (4)
Mertz, Henry Oliver.....1711 N. Capitol Ave. (7)
Michael, Amos C.....1040 W. Michigan St. (7)
Michell, Arthur J.....920 Underwriters Bldg. (4)
Middleton, Harvey N.....2104 Blvd. Pl. (2)
Miller, Albert W.....207 E. Morris (2)
Miller, J. Don.....514 Hume Mansur Bldg. (4)
Miller, Raleigh S.....709 E. 63rd St. (5)
Miller, Ray D.....3769 Park Ave. (5)
Miller, Roland E.....1315 W. 32nd St. (8)
Miller, William T.....2411 E. Tenth St. (1)
Millikan, William.....2620 E. 59th St. (5)
Mitchell, Earl H.....2617 W. Michigan St. (8)
Mitchell, Raymond E.....3419 E. Tenth St. (1)
Moenning, Walter P.....241 N. Penn. St. (4)
Molt, William F.....529 Bankers Trust Bldg. (4)
Montgomery, W. F....311 Hume Mansur Bldg. (4)
Moore, Ben B.....414 Hume Mansur Bldg. (4)
Moore, Harold T.....Methodist Hospital (7)
Moore, Robert M....1007 Hume Mansur Bldg. (4)
Moriarty, John R.....357 E. Minnesota St. (2)
Morrison, Lewis E. H...5857 Indianaola Ave. (5)
Morton, Walter P....623 Hume Mansur Bldg. (4)
Moser, Rollin H.....408 Hume Mansur Bldg. (4)
Mothersill, Mark H.....Eli Lilly & Co. (6)
Moulton, Lillian G.....R. R. 14, Box 520 (44)
Moutoux, Joseph E.....2346 Shelby St. (3)
Mozingo, A. E.....1129 S. Meridian St. (2)
Mueller, Lillian B.....City Hospital (7)
Mumford, E. B.....320 N. Meridian St. (4)
Muntz, H. H.....I. U. Medical Center (7)
Myers, Charles W.....City Hospital (7)
Myers, Roy V.....1904 N. Rural St. (1)
Nafe, Cleon A.....822 Hume Mansur Bldg. (4)
Need, Lewis T.....1927 S. Meridian St. (2)
Neely, Alonzo S.....305 Fountain Square Bldg.
Nehil, Lawrence W...601 Hume Mansur Bldg. (4)
Neier, Oliver C.....5508 E. Washington St. (1)
Nestmann, Ralph H.....23 N. Temple Ave. (1)
Nie, Louis W.....4815 Guilford (5)
Noble, Thos. B., Jr..1008 Hume Mansur Bldg. (4)
Noble, Thos. B., Sr..1008 Hume Mansur Bldg. (4)
Nolting, Henry F.....261 W. 40th St. (8)
Nonte, Leo R..Vet. Hospital, Cold Springs Rd. (44)
Norman, Olin B.....922 Hume Mansur Bldg. (4)
Norman, William H...908 Hume Mansur Bldg. (4)
Norris, Howard Lee...794 Hume Mansur Bldg. (4)
Norris, Mary Alice....404 Hume Mansur Bldg. (4)
Ochsner, Harold C.....Methodist Hospital (7)
O'Dell, Thomas Allen.....2357 Station St. (1)
Olvey, Ottis N.....4121 Central Ave. (5)
Orders, Clark E.....440 Bankers Trust Bldg. (4)
Otten, Claude F...812 Chamber of Com. Bldg. (4)
Ottinger, Ross C.....912 Hume Mansur Bldg. (4)
Owen, John E.....605 Hume Mansur Bldg. (4)
Owens, Tracy C.....2823 N. Meridian St. (8)
Padgett, E. E....423-24 Hume Mansur Bldg. (4)
Pandolfo, Harry.....2206 Madison Ave. (2)
Parke, D. Davis.....1847 Medford Ave. (8)
Parker, John F.....1706 E. Washington St. (1)
Parker, Portia 2226 W. Michigan St. (8)
Patton, Martin T.....111 W. 30th St. (8)
Paulissen, George T.....St. Vincent's Hospital (7)
Pearson, Lyman R..311 Hume Mansur Bldg. (4)
Pebworth, Aubrey C.....1625 W. Morris St. (3)
Peck, Franklin B.....749 S. Alabama St. (6)
Peiree, James D.....Lilly Research Clinic, City Hospital (7)
Pennington, Walter E..214 Hume Mansur Bldg. (4)
Permer, Erwin.....734 E. 30th St. (5)
Peters, Robert J. D.....3203 E. Michigan St. (1)
Petranoff, T. V.....3367 W. Michigan St. (8)
Pettijohn, Fred L.....2460 Central Ave. (5)
Pfaff, Dudley A.....723 Hume Mansur Bldg. (4)
Pfaff, John A.....703 Hume Mansur Bldg. (4)
Pfafflin, Charles A....445 Bankers Trust Bldg. (4)
Pilcher, Jack E.....202 Hume Mansur Bldg. (4)
Pollak, Lewis 1602 N. Pennsylvania (2)
Price, James Owen....St. Vincent's Hospital (7)
Prough, Wendell A.....Address Unknown
Pryor, Richard C.....6111 College Ave. (5)
Quigley, Joseph B 2120 E. 10th St. (1)
Rabb, Harry S.....3139 E. 10th St. (1)
Raber, Robert M.....419 E. 48th St. (5)
Ralston, John D.....115 E. 16th (2)
Ramsey, Frank B.....202 Hume Mansur Bldg. (4)
Reed, Jewett V....820 Chamber of Commerce (4)
Reed, Philip B.....1820 E. 10th St. (1)
Rees, Russel C.....6114 E. Washington (1)
Reid, Charles A.....2445 Shelby (3)
Reisler, Simon.....318 Bankers Trust Bldg. (4)
Reiss, Jack.....Veterans Hospital, Cold Springs Rd. (44)
Rhodes, Theodore D...307 Hume Mansur Bldg. (4)
Rice, Raymond M.....Eli Lilly and Company (6)
Rice, Thurmon B Ind. St. Board of Health (7)
Richter, Arthur B.....720 Hume Mansur Bldg. (4)
Ricketts, Joseph W....806 Hume Mansur Bldg. (1)
Ridgeway, Ora W.....411 E. 16th St. (2)
Ridgway, Alton V.....4238 Norwaldo (5)
Rigg, John F.....421 Hume Mansur Bldg. (4)
Rinker, Earl B.....22 E. 57th St. (5)
Ritchey, James O....608 Hume Mansur Bldg. (4)
Ritter, Wayne L....312 Hume Mansur Bldg. (4)
Robertson, Ray B....6118 E. Washington St. (1)
Rogers, Thomas P.....5840 Wiathrop Ave. (5)
Roll, Edmund C.....3814 E. 39th St. (1)
Roller, Charles W.....1437 Shelby St. (3)
Romberger, F. T., Jr.....Coleman Hospital (7)
Rosenak, Bernard D...226 Hume Mansur Bldg. (4)
Ross, Alexander T....822 Hume Mansur Bldg. (4)
Row, D. Hamilton...906 Hume Mansur Bldg. (4)
Rubin, Gerald A.....5935 Spring Mill Rd. (5)
Ruddell, Karl R.....301 Hume Mansur Bldg. (4)
Ruddell, Keith R....301 Hume Mansur Bldg. (4)
Rudesill, Cecil L....405 Hume Mansur Bldg. (4)
Rupel, Ernest.....419 Hume Mansur Bldg. (4)
Rust, Byron K.....3740 Central Ave. (5)
Ruth, Martin L.....4330 E. Washington St. (1)
Rutherford, Cyrus W..4601 N. Pennsylvania St. (5)
Ryan, Glen V.....2428 W. 16th St. (8)
Sage, Russell A.....505 Hume Mansur Bldg. (4)
Salb, John A.....650 Bankers Trust Bldg. (4)
Salb, Max C...823 Chamber of Commerce Bldg. (4)
Sales, Louis M.....Veterans Hospital (44)
Salzman, Morris.....1119 S. Meridian St. (2)
Sandorf, Marvin H.....1102½ Prospect (3)
Sandy, William A.....3227 Park Ave. (5)
Seamahorn, Malcolm O..1040 N. Delaware St. (2)
Schaefer, C. Richard.....20 Barr Assn. Bldg. (4)
Scheier, Emil W.....1706 Prospect St. (3)
Schechter, John S.....City Hospital (7)
Schneider, Carl J.....1008 N. Beville Ave. (1)
Schuchman, Gabriel.....3451 College Ave. (5)
Schweitzer, Ada E.....5736 N. Michigan Rd. (5)
Schulze, Hans A.....98 N. Ewing (1)
Scott, Charles C.....Eli Lilly & Company (2)
Scott, Ivan W.....321 Hume Mansur Bldg. (4)
Scott, Samuel L.....Veterans Hospital, Cold Springs Rd. (44)
Seaman, Charles F...1010 Hume Mansur Bldg. (4)
Seaton, Albert...American United Life Ins. Co. (6)
Sedam, Herbert L.....4173½ College Ave. (5)
Segar, Louis H.....226 Hume Mansur Bldg. (4)
Sexson, Hiram T.....1301 College Ave. (2)
Shafer, Marion R....614 Hume Mansur Bldg. (4)
Sheehan, Francis G.....5503 E. Washington (1)
Sheridan, Joseph L.....Address Unknown
Sherster, Harry.....1135 S. Meridian St. (2)
Sarader, Jack C.....A.P.O. 980, c/o Postmaster, Seattle, Wash.
Shugart, Joseph A.....St Vincent's Hospital (7)
Shuler, Lacey L.....510 Hume Mansur Bldg. (4)
Shullenberger, W. A.....3740 Central Ave. (5)
Sicks, Okla W.....301 Hume Mansur Bldg. (4)
Siekerman, C. W.....2612 Madison Ave. (3)
Siersdorfer, T. N.....6003 W. Washington St. (8)
Sigmond, Harvey W...1010 Hume Mansur Bldg. (4)
Simmons, F. H.....I. U. Medical Center (7)
Sims, J. Lawrence,...303 Hume Mansur Bldg. (4)
Sluss, D. H..808 Chamber of Commerce Bldg. (4)
Sluss, J. W..808 Chamber of Commerce Bldg. (4)
Smiley, James H.....4201 E. Michigan St. (1)
Smith, David J.....Methodist Hospital (7)
Smith, David L.....723 Hume Mansur Bldg. (4)
Smith, E. Rogers.....822 Hume Mansur Bldg. (4)
Smith, Francis C.....983 N. Arlington Ave. (1)
Smith, James M.....2969 N. Meridian St. (7)
Smith, Lester A.....238 Hume Mansur Bldg. (4)
Smith, Roy Lee.....737 Underwriters Bldg. (4)
Smith, Wilbur F.....3424 College Ave. (5)
Smithson, Robert A.....City Hospital (7)
Snider, Byron.....803 Hume Mansur Bldg. (4)
Solomon, Reuben A...414 Hume Mansur Bldg. (4)
Souter, Martha C.....3360 N. Meridian St. (8)
Sovine, J. W.....720 Hume Mansur Bldg. (4)
Spahr, John F., Jr...902 Hume Mansur Bldg. (4)
Spalding, Joseph J.....I. U. Medical Center (7)
Sparks, Alan L.....1024 Hume Mansur Bldg. (4)
Spink, Urbana.....238 K. of P. Bldg. (4)
Spivey, Russell J.....2616 N. Pennsylvania St. (7)
Spolyar, Louis W.....Board of Health, 1098 W. Michigan St. (7)
Sputh, Carl B., Jr.....301 Bar Ass'n Bldg. (4)
Sputh, Carl B., Sr.....301 Bar Ass'n Bldg. (4)
Stadler, Harold E.....5508 E. Washington St. (1)
Stalker, James B.....43 W. 30th St. (8)
Stangle, William J.....Methodist Hospital (7)
Stanley, John S.....2845 Forest Manor Ave. (1)
Stauffer, Geo. E.....Regional Office, Veterans Hospital (44)
Stayton, Chester A., Jr....5867 Central Ave. (5)
Stayton, C. A., Sr....313 Hume Mansur Bldg. (4)
Steele, Brandt F.....608 Hume Mansur Bldg. (4)
Steele, Paul W.....Veterans Hospital (44)
Stephens, K. H.....501 Hume Mansur Bldg. (4)
Stern, Nathan.....601-3 Bankers Trust Bldg. (4)
Stevens, Sydney L....3375 Forest Manor Ave. (1)
Stirling, E. H.....Address Unknown
Stoeffler, Walter State Board of Health, 1098 W. Michigan St.
Stone, Alvin T.....6202 College (5)
Stone, David F.....Sunnyside Sanatorium (44)
Storey, D. Edmund.....Veteraus Hospital, Cold Springs Rd. 44)
Storey, Joseph L.....3434 N. Illinois St. (8)

MARION COUNTY—(Cont.)

Indianapolis

Storms, Roy Basil.....1109 Roosevelt Bldg. (4)
Stroup, Tyler J.....216 K. of P. Bldg. (4)
Stucky, Elsworth K.....1355 Madison (2)
Stygall, James H.....1221 N. Delaware St. (2)
Sudranski, Herbert F..624 Hume Mansur Bldg. (4)
Sullenger, Adron A.....City Hospital (7)
Sullivan, Thomas L.....28 E. 16th St. (2)
Sutton, W. E.....Methodist Hospital (7)
Swan, John R.....915 Hume Mansur Bldg. (4)
Swayne, Jap F.....1410 E. Washington St. (1)
Talbott, Dan E.....1020 Hume Mansur Bldg (4)
Tanner, Henry S 1010 Hume Mansur Bldg. (4)
Taylor, Clifford C.....St. Vincents Hospital (7)
Taylor, Frederic W...408 Hume Mansur Bldg. (4)
Teague, Frank W.....501 Hume Mansur Bldg. (4)
Tetter, Elden John.....Eli Lilly & Co. (6)
Teixler, Victor A 224 Hume Mansur Bldg. (4)
Tether, Joseph E.....I. U. Medical Center (7)
Tharpe, Ray.....301 Hume Mansur Bldg (4)
Thatcher, H. K., Jr.....110 W. Maple Rd. (8)
Thomas, Fred A.....St. Vincents Hospital (7)
Thomas, Lowell L..812 Chamber of Com. Bldg. (4)
Thomas, Morris E....715 Medical Arts Bldg. (4)
Thompson, Charles F..320 Hume Mansur Bldg. (4)
Thompson, John V.....1221 N. Delaware St. (2)
Thompson, Paul V.....1320 N. Delaware (2)
Thornburg, K. E....1015 Hume Mansur Bldg. (4)
Thornton, Harold C.....St Vincents Hospital (7)
Thrasher, John R...823 Chamber of Com. Bldg. (4)
Thurston, Alpheus L 510 Bar Ass'n Bldg. (4)
Thurston, Harrison S Box 162, Indianapolis
Thurston, Herbert F..812 Hume Mansur Bldg. (4)
Tinney, William E....900 Underwriters Bldg. (4)
Tinsley, Frank W.....603 K. of P. Bldg. (4)
Tinsley, Walter B.....603 K. of P. Bldg. (4)
Tischer, E. Paul.....404 Hume Mansur Bldg. (4)
Torrela, Jose A 3001 N. New Jersey St. (5)
Travis, Julius C., Jr.....402 K. of P. Bldg. (4)
Tremor, Victor C.....Veterans Hospital (44)
Trusler, Harold M...1015 Hume Mansur Bldg. (4)
Tucker, Warren S....414 Hume Mansur Bldg. (4)
Van Meter, C. Powell.....3419 E. 10th St. (1)
Vandemark, W. E City Hospital (7)
Vandivier, Robert M .515 Hume Mansur Bldg. (4)
Van Nuys, John D.....I. U. Medical Center (7)
Van Osdol, Harry A.....828 C. of C. Bldg. (4)
Van Vactor, Helen D...226 Hume Mansur Bldg. (4)
Vollrath, Victor A.....218 S. Audubon Rd. (1)
Voyles, Charles F.....715 Underwriters Bldg. (4)
Voyles, Glenn Q.....826 C. of C. Bldg. (4)
Waldo, Jeane Thayer..619 Hume Mansur Bldg. (4)
Wales, E. deWolfe...916 Underwriters Bldg. (4)
Walker, Frank C.....414 Hume Mansur Bldg. (4)
Walker, Robert K.....413 E. 34th St. (5)
Walters, Charles E.....240 N. LaSalle St. (1)
Ward, Wesley C.....116 E. 49th St. (5)
Warfel, Frederick C Veterans Hospital (44)
Warman, Alvah P.....709 E. Maple Rd. (5)
Warriner, James B.....Methodist Hospital (7)
Warvel, John H.....614 Hume Mansur Bldg. (4)
Waymire, Elbert S.....1827½ College Ave. (2)
Wehrman, Jule O.....504 Hume Mansur Bldg. (4)
Weigand, Clayton G.....Eli Lilly & Co. (6)
Weil, Harry J.....443 N. Hamilton Ave. (1)
Weiss, Jason 4909 W. 15th St. (8)
Weller, Charles A ..615 Hume Mansur Bldg. (4)
West, Joseph L.....6318 W. Washington (8)
Westfall, B. Kemper.....1 W. 28th St. (8)
Westfall, John B.....2961 N. Sherman Drive (44)
Weyerbacher, A. F...709 Hume Mansur Bldg. (4)
Wheeler, John T.....1102 I. O. O. F. Bldg. (4)
Whitlock, Francis C...4032 E. Washington St. (1)
White, Donald J.....502 Bankers Trust Bldg. (4)
Whitehead, John M.....1544 Roosevelt Ave. (1)
Wilkens, Irvin W.....1743 Shelby St. (3)
Williams, Charles D.....2405 Station St. (1)
Williams, Clifford L.....1098 W. Michigan St. (7)
Williams, H. S., Jr.....145 E. 16th St. (2)
Wilmore, Ralph C.....I. U. Medical Center (7)
Wilson, Oliver R.....512 E. 28th St. (5)
Winters, Matthew.....510 E. 38th St. (5)
Wise, William.....120 E. 22nd St. (2)
Wishard, W. N., Jr.....1711 N. Capital Ave. (7)
Wolfram, Don J.....502 Hume Mansur Bldg. (4)
Wood, Donald E.....6463 N. Illinois St. (5)
Wood, George.. 222 Bar Assn. Bldg. (4)
Woodard, A. S., Jr.....668 E. Maple Rd. (5)
Woods, William V....508 Hume Mansur Bldg. (4)
Woolery, Richard H.....City Hospital (7)
Woolling Kenneth R...6930 Washington Blvd. (5)
Workman, William S. (H).....Address Unknown
Worley, J. P.....5831 E. Washington St. (1)
Wright, J. William....304 Hume Mansur Bldg. (4)
Wyttenbach, F. C.....1154 Lee St. (3)
Wyttenbach, John E...524 Hume Mansur Bldg. (4)
Young, James W.....6302 Guilford (5)
Young, John M.....3209 N. Meridian (8)
Lewis, Robert J.....Lawrence
Asher, Ernest O.....New Augusta
Asher, James W.....New Augusta
Paynter, Morris B.....Southport
Deal, Eleanor.....1544 Main St., Speedway City
Hanna, Thomas A...1462 Main St., Speedway City
Jones, George L.....Wanamaker
Alward, John H....Akron City Hospital, Akron, O.
Andrews, D. Lee.....1501 Bardstown Rd., Louisville, Ky.
Baumgart, E. T 926 E. Main St., Danville, Ill.
Baumrucker, G. O...1140 Lake St., Oak Park, Ill.
Bernstein, Joseph..126 W. 73rd St., New York, N. Y.
Bill, Robert O 2331 F St., San Diego, Calif.
Blackstone, Jack C.....Nashville Gen. Hospital, Nashville, Tenn.
Boling, Roderick L.....Mound Park Hospital, St. Petersburg, Fla.
Brill, I. Wm.....University Hospitals, Ann Arbor, Mich.
Burton, Frank Hanly.....415-18 Phoenix Bldg., Butte, Mont.
Cheney, Frederick D.....Veterans Hospital, Thomasville, Ga.
Cook, Norman R.....Mason General Hospital Brentwood, L. I., New York.
Davis, George D.....1215 4th Ave., S W., Rochester, Minn.
DeLawter, Hilbert H Menninger Foundation, School of Psychiatry, Topeka, Kan.
DeLawter, Pierre.....U. S. Naval Hospital, Long Beach, Calif.
Deputy, Rolland....2321 4th Ave., Seattle, Wash.
Ettl, Edward J...1108 N. 7th St., Temple, Texas
Ferree, John W.....Am. Social Hygiene Assn., 1790 Broadway, New York 19, N. Y.
Gilliom, Luther Allen..Walter Reed Gen. Hospital, Washington, D. C.
Graham, Alois Bachman...Reynardia-Ligonier, Pa.
Green, Myron H Lahey Clinic, Boston, Mass.
Greer, Oliver W.....V. A. Branch Office 13, Denver, Colo.
Harding, Myron R 37 Bryden Circle, Fayetteville, N. C.
Harvey, Verne K U. S. Civil Service Comm., Washington, D. C.
Hilldrup, Don G.....Fort Sill, Okla.
Hollingsworth, Maurice.....Los Angeles, Calif.
Hyman, Bernard.....5489 Cornell Ave., Chicago 15, Ill.
Jacobs, Lewis G.....Bruns General Hospital, Santa Fe, N. M.
Katterjohn, James C...Dept. of Radiology, Univ. of Pennsylvania, Philadelphia 4, Pa.
Lockhart, Jack M...416 Oxford Pl., Louisville, Ky.
McQueen, William.....Guilford Co. Sanitarium Jamestown, N. C.
Mansfield, Max R.....423 Biltmore Way, Coral Gables, Fla.
Maehland, Harold F.....Washington, D. C.
Marshall, William P.....Kalamazoo, Mich.
Morris, Marion H.....3400 Spruce St., Dept. of Orthopaedic Surgery, Philadelphia, Pa.
Norwick, Sydney S...School of Public Health, Univ. of Michigan, Ann Arbor, Mich.
Nourse, Myron H.....U. S. Naval Hospital, Corona, Calif.
Pebworth, J. T.....Box 124, Tyrone, N. M.
Reul, Thomas W..108 Ashwood Ave., Summit, N.J.
Reynolds, F. C....4952 Maryland, St. Louis, Mo.
Robinson, Frank C.....14301 Bay Drive, St. Petersburg 6, Fla.
Rueh, Monroe K.....McCornaek Gen. Hosp., Pasadena, Calif.
Rudolph, Stephen J., Jr.....Philadelphia Lying-In Hospital, 807 Spruce, St., Philadelphia, Pa.
Sage, Charles V.....Brownstown, Ind.
Schmidt, Loren F.....St. Joseph's Hospital, St. Joseph, Mo.
Sessions, S. Kenosha..102 E. Spring St., Anna, Ill.
Smith, Lawson Fry.....LaVeta, Colo.
Thomas, Morris C...T. B. Unit, Veterans Hospital, Dayton, O.
Walker, James S.....Johns Hopkins Hospital, Baltimore, Md.
Young, Woodson C...Bureau of Medicine and Surgery, Research Div., Washington 25, D.C.
Shields, Tom S.....University of Pennsylvania, Philadelphia, Pa.

MARSHALL COUNTY

Alexander, James M.....Argos
Johns, N. C Argos
Kelly, Frank H.....Argos
Graham, Cova R.....Bourbon
Marshall, George L.....Bourbon
Bowen, Otis Bremen
Cripe, Earl P.....Bremen
Thompson, John M.....Bremen
Baker, Milan D.....Culver
Mackey, C. G Culver
Reed, Donald Culver
Tallman, Homer H.....Culver
Connell, Paul S Plymouth
Holtzendorff, Charles F. (H).....Plymouth
Irey, Paul R.....Plymouth
Kaler, James Plymouth
Klingler, Maurice O.....Plymouth
Perry, F. G.....Plymouth
Pomeroy, Rex K.....Plymouth
Possolt, Thomas R Plymouth
Stephens, Robert C. (H).....Plymouth
Tripp, Harry D.....Plymouth
Vore, L. W.....Plymouth
Thompson, Alfred A.....Tyner
Burke, Homer L.....Castaner, Porto Rico

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shroek, Ethan E.....Amboy
Line, Homer E.....Chili
Frybarger, Samuel S.....Converse
Mlott, Frederick R.....Converse
Kratzer, Eugene F.....R. R. 3, Kokomo
Rendel, Charles F.....Mexico
Rendel, Harold E.....Mexico
Barnett, Ralph E.....Peru
Berkebile, John B.....Peru
Burrous, E. L.....Peru
Carlson, Edward A.....Peru
Ferrara, Donald W.....Peru
Ferrara, Samuel J.....Peru
Herd, C. R.....Peru
Horton, George R.....Peru
Lynn, Frank M. (H).....Peru
Malouf, Stephen D.....Peru
Wildman, Roscoe E.....Peru
Yarling, John E.....Peru

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Ball, Thomas Z. (H).....403 Ben Hur Bldg.
Collett, George A.....419 Ben Hur Bldg.
Cooksey, Thomas L. (H)..109½ S. Washington St.
Daugherty, Fred N.....106½ S. Green St.
Dodds, Wemple Culver Hospital
Echternacht, Arthur P.....Culver Hospital
Griffith, James B.....218 S. Green St.
Howard, Chester W.....316 Ben Hur Bldg.
Kinnaman, Howard A.....206 Ben Hur Bldg.
Kirtley, James M.....416 Ben Hur Bldg.
Lingeman, Byron N.....419 Ben Hur Bldg.
Millis, Robert J.....310 Ben Hur Bldg.

MONTGOMERY COUNTY—(Cont.)

Crawfordsville

Mount, William M.....413 Ben Hur Bldg.
Peacock, Norman F.....219 Ben Hur Bldg.
Pierson, Robert H.....305 E. Main St.
Pollom, Robert R.....312 Jones Ave.
Sharp, John L.....219 Ben Hur Bldg.
Straughan, Walter L.....Ben Hur Bldg.
Taylor, Willard M.....315 Ben Hur Bldg.
Wallace, Hawthorne C.....419 Ben Hur Bldg.
Humphreys, John W.....Darlington
Otten, Ralph E.....Darlington
Denny, Frank T.....Ladoga
Gross, Maurice E.....Ladoga
Walterhouse, Harrison K.....Ladoga
Kindell, Hurschell D.....New Richmond
Johnson, Frank D.....Waynetown
Parker, Carl B.....Wingate

MORGAN COUNTY

Alexander, Percy M.....Martinsville
Bothwell, Camden G.....Martinsville
Dickens, K. L.....Martinsville
Dutton, Hayes H.....Martinsville
Gray, Leon.....Martinsville
Grimes, Jay H.....Martinsville
Pitkin, Edward M.....Martinsville
Pitkin, McKendree C.....Martinsville
Willan, Horace R.....Martinsville
Williams, Paul D.....Martinsville
Murphy, Maurice G.....Morgantown
Comer, Charles W.....Mooresville
Comer, Jonathan E.....Mooresville
Comer, Kenneth E.....Mooresville
Karpel, Bernard.....Mooresville
VanBokkelen, Robert W.....Mooresville
White, Claude H.....Mooresville
Hughes, Lawrence M.....Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M.....Albion
Morr, John W. (H).....Albion
Nash, Justin R.....Albion
Sneary, Kenneth D.....Avilla
Veazey, William M. (H).....Avilla
Switzer, Robert E.....Cromwell
Goodwin, Columbus B. (H).....Kendallville
Gutstein, Richard R.....Kendallville
Hardy, Charles F.....Kendallville
Lawson, Isaac H.....Kendallville
Messer, Frank W.....Kendallville
Munk, Cleorie E.....Kendallville
Seybert, Joseph D.....Kendallville
Williams, Harold O.....Kendallville
Young, Simon J. (H).....Kendallville
Schutt, James B.....Ligonier
Stultz, Quentin F.....Ligonier
Pulskamp, Bertrand H.....Woleottville
Fair, John R.....Wolf Lake
Luckey, Harold A.....Wolf Lake
Luckey, Robert C.....Wolf Lake
Fipp, August L.....Rome City
Shortz, Gerald..129 Granger St., Wollaston, Mass.
Arnold, Ralph D.....Sheridan, Wyo.
Rarick, Arnold J...Veterans Hosp., Nashville, Tenn.

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Colglazier, Granville G.....Leipsic
Baker, Robert E. (H).....Orleans
Schoolfield, William E.....Orleans
Clark, Ivan A.....Paoli
Hammond, Keith.....Paoli
Spears, John K.....Paoli
Teaford, Schuyler F.....Paoli
Boyd, Clarence E.....West Baden
Miller, Henderson L.....West Baden

OWEN-MONROE COUNTIES

Bloomington

Austin, Fred H. (H).....110 E. 4th St.
Baxter, Neal E.....306 E. 5th St.
Borland, Raymond M.....114 N. Lincoln St.
Boulware, Judson.....116 E. 4th St.
Buckingham, Richard E.....344 College Ave.
Culmer, Walter N.....426 S. College Ave.
Dalton, Naomi L.....114 E. 7th St.
DeMotte, Russell.....214 E. Kirkwood
Geiger, Dillon D.....300 E. Kirkwood
Hepner, Herman S.....312 N. Walnut St.
Holland, Charles E.....712 N. Washington St.
Holland, Deward J.....313 N. College Ave.
Holland, Philip T.....108 W. 7th St.
Karsell, William A.....1401 E. 10th St.
Kime, Edwin N.....201 Medical Bldg.
Luzadder, John E. (H).....123½ W. 5th St.
Lyons, Robert E.....321 E. 5th St.
Myers, Burton D. (H).....424 N. Walnut St.
Owen, Abraham M.....200 S. Washington St.
Owen, Margaret A.....200 S. Washington St.
Ramsey, Hugh S.....121 E. 7th St.
Reed, William C.....307 E. 5th St.
Rogers, Otto F., Jr.....210 N. Washington St.
Rogers, Robert C. (H).....210 N. Washington St.
Ross, Ben R.....314 E. 7th St.
Sebell, Harry D.....114 N. Lincoln St.
Sehuman, Edith B.....Indiana University
Smith, Hersehel S.....218 E. Kirkwood
Smith, Rodney D. (H).....115 N. Washington St.
Topolgus, James N.....114 E. 4th St.
Wilson, Talmage L.....301 E. Kirkwood
Wiltshire, James W.....103 S. Lincoln St.
Yocum, Boaz (H).....Coal City
Smith, Paul E.....Ellettsville
Hazel, James T. (H).....Freedom
Charles H. Stouder.....Gosport
Mitchell, George L.....Smithville
Brown, Marcel S.....Spencer
Kay, Oran E.....Spencer
Pectol, Charles F.....Spencer
Thom, Julia S.....Spencer
Smith, John H.....1675 Oak Knoll Circle, S. E., Atlanta, Ga.
Thom, Jay W.....Camp Campbell, Ky.

PARKE-VERMILLION COUNTIES

Greene, Frederick G.....Bloomingdale
Brown, Ralph E.....Cayuga
Darroeh, Samuel C.....Cayuga
Casebeer, Paul B.....Clinton
Gerrish, Wakefield D.....Clinton
Kercheval, John M.....Clinton
Rosenfeld, Norman B.....Clinton
White, Charles M.....Clinton
White, Isaac D.....Clinton
Lauer, Dorothy B.....Dana
Myers, William C.....Dana
Britton, Welbon D.....Montezuma
Hegarty, William M., Jr.....Newport
Saunders, Jones L.....Newport
Johnson, William A.....Perrysville
Bloomer, Joseph R.....Rockville
Bloomer, Richard S.....Rockville
Dowell, Emil H.....Rockville
Harstad, Casper.....Rockville
Lewis, James L.....Rockville
Merrell, Basil M.....Rockville
Noblitt, James S.....Rockville
Pirkle, Hubert B.....Rockville
White, Chester S.....Rosedale
Green, Silva Ira.....St. Berniee
Keith, Freeman E.....St. Bernice

PERRY COUNTY

Epple, Stephen L.....Bristow
Bush, Hargis R.....Cannelton
Schriefer, Ernest E.....Cannelton
Taylor, John E. (H).....Leopold
Coultas, Porter J.....Tell City
Dome, Hardin S.....Tell City
Dukes, David.....Tell City
Glenn, Fred C.....Tell City
Hargis, William T. (H).....Tell City
James, Nicholas A.....Tell City
Snyder, Earl R.....Troy

PIKE COUNTY

Dickinson, Gordon A.....Petersburg
Kime, John T. (H).....Petersburg
Logan, Austin R.....Petersburg
Rice, Thompson R. (H).....Petersburg
Taylor, Daniel E. (H).....Velpen
DeTar, George B.....Winslow
Miller, Lawrence R.....Winslow
Miller, Jack B.....Hotel Bolton, Cleveland, O.

PORTER COUNTY

Dale, Joseph W.....Chesterton
Griffin, Joseph P.....Chesterton
Hall, Thomas C.....Chesterton
Butman, William C.....Hebron
Kleinman, Francis J.....Hebron
Dittmer, Jack E.....Kouts
Dittmer, Samuel E.....Kouts
Dittmer, Thomas L.....Kouts
Anderson, Wendell C.....Valparaiso
Brown, James C.....Valparaiso
Davis, Carl M.....Valparaiso
DeGrazia, Eugene.....Valparaiso
DeWitt, Charles H.....Valparaiso
Douglas, George R.....Valparaiso
Eades, Ralph C.....Valparaiso
Frank, John R.....Valparaiso
Fyfe, Malcolm B.....Valparaiso
Loring, Mark L.....Valparaiso
Miller, Ebbo H.....Valparaiso
Nash, Charles B.....Valparaiso
Powell, Edgar H.....Valparaiso
VanWinkle, Arthur J.....Valparaiso
Vietzke, Paul C. F.....Valparaiso
Gordon, Joseph L.....Wheeler
Cramp, Arthur J. (H)..Box 1237, Hendersonville, North Carolina

POSEY COUNTY

Montgomery, Samuel B.....Cynthiana
Ropp, Harold E.....New Harmony
Thompson, Lewis R.....New Harmony
Boren, Paul.....Poseyville
Boren, Samuel W. (H).....Poseyville
Woods, Arba L.....Poseyville
Challman, William B.....Mount Vernon
Herr, John W.....Mount Vernon
Oliphant, Frank W.....Mount Vernon
Ranes, John R.....Mount Vernon
Vogel, L. John.....Mount Vernon
Williams, Frederic N.....Mount Vernon
Jenkinson, William E.....Albany Hospital, Albany, N. Y.

PULASKI COUNTY

Ives, Raymond J.....Francesville
Linton, Charles E.....Medaryville
Kelsey, Arthur J.....Monterey
Carneal, Thomas E.....Winamac
Halleck, Harold J.....Winamac
McCaskey, George H.....Winamac

PUTNAM COUNTY

Veach, Lester W.....Bainbridge
Veach, Richard L.....Bainbridge
Hurst, Everett M.....Cloverdale
O'Brien, Tracy M.....Danville
Aker, Charles L.....Greencastle
Dettloff, Frederick.....Greencastle
Fuson, Wenfred J.....Greencastle
Gillespie, Joseph F. (H).....Greencastle
Hutcheson, Walter R.....Greencastle
Johnson, James B.....Greencastle
McGaughey, Walter M.....Greencastle
Parker, George F.....Greencastle
Rhea, Gilbert D.....Greencastle
Steele, Dick J.....Greencastle
Tennis, George T.....Greencastle
Tipton, William R.....Greencastle
Wiseman, V. Earle.....Greencastle
Gwaltney, Loral F.....Roachdale
Irwin, Glenn W., Jr.....Roachdale
Osborne, Harry S.....Roachdale
Richards, Edgar E.....Russellville
Schauwecker, Cleon M.....3402 W. Wells St., Milwaukee, Wis.

RANDOLPH COUNTY

Nixon, Byron Farmland
Unger, L. L. Farmland
White, Harvey E. Farmland
Harmon, Wayne Lynn
Jordan, Leo E. Lynn
Martin, Charles E. Lynn
Slick, Crystal R. Lynn
Shallenberger, Henry R. Modoc
Barnard, Pliny C. (H) Parker
Hinchman, Jean Parker
Henderson, Arvin Ridgeville
Schenk, George H. Ridgeville
Chambers, Leroy B. Union City
Davis, George H. Union City
Phipps, David L. (H) Union City
Phipps, Leland K. Union City
Reid, Robert W. Union City
Ruby, Fred M. Union City
Voisinet, Raymond A. Union City
Wills, Benjamin F. Union City
Brenner, Andrew M. Winchester
Brenner, Ivan E. Winchester
Dininger, William S. Winchester
Engle, Russell B. Winchester
Overmyer, Jay W. Winchester
Painter, Lowell W. Winchester
Robison, John S. Winchester
Sparks, Paul W. Winchester
Stoelting, Vergil K. University of Iowa Hospital, Iowa City, Ia.

RIPLEY COUNTY

Bigham, John C. Batesville
Hisrich, Lloyd W. Batesville
Obery, George A. Batesville
Hunter, Lowell G. Milan
Warn, William J. Milan
Whitlatch, Arthur Milan
Whitlatch, Irving A. Milan
Row, George S. Osgood
Smith, R. Lee Osgood
McConnell, William C. Sunman
Hopkins, Lester H. Versailles
Moran, Noel D. Versailles

RUSH COUNTY

Coleman, William S. Carthage
McNabb, George B. Carthage
Worth, C. Willard Milroy

Rushville

Atkins, Clarence C. 225 N. Morgan St.
Dean, Donald I. 4th and Main St.
Denny, Melvin H. 224 N. Morgan St.
Green, Frank, Jr. 144 E. 2nd St.
Green, Lowell M. 127 W. 3rd St.
Johnson, Robert B. 227 N. Morgan St.
Kennedy, Robert O. 118 W. 3rd St.
Nutter, Wyndham H. 205 W. 3rd St.
Shanks, Roy E. I. O. O. F. Bldg.
Smullen, Williard 224 Morgan St.
Lee, John M. 1814 Grand Ave, Dayton 7, O.

ST. JOSEPH COUNTY

How, John T. Lakeville
How, Louis E. Lakeville

Mishawaka

Bassler, Carl R. Mishawaka Trust Bldg.
Christophel, Verna 109 W. 3rd St.
Duvall, William N. 118 N. Church St.
Ganser, Richard A. 203 Polis Bldg.
Goethals, Charles J. 602 Lincolnway, W.
Hutchinson, B. M. 117½ Lincolnway, E.
Joest, Charles O. 103 W. 3rd St.
Logan, Francis W. 208 First Nat. Bank Bldg.
Luthy, Karl Medical Dept., Ball Band Co.
Parker, E. E. St. Joseph Hospital
Rosenwasser, Jacob 826 E. 3rd St.
Orr, Robert 124 S. Race St.
Sirlin, Edward M. 113½ Lincolnway, W.
Spalding, Wendell L. 101 Lincolnway, E.
Van Rie, Leo P. 116 S. West St.
Ward, James W. 316 Lincolnway, E.
Whitlock, Merle E. 123 W. 4th St.
Wurster, Herbert C. 221 E. 3rd St.
Wygant, Marion D. 116 W. 3rd St.
Wyland, Byron J. 116 W. 3rd St.
Zimmer, Henry J. 119½ Lincolnway, W.
Luzadder, John E., Jr. New Carlisle
Hardy, John J. North Liberty

South Bend

Abel, Joseph A. 1222 Western Ave.
Acker, Robert B. 418 Sherland Bldg.
Arisman, Ralph K. 711 Odd Fellow Bldg.
Baker, Walter H. 120 N. Lafayette Blvd.
Balla, Morris 404 Sherland Bldg.
Beardsley, Oliver B. 120 N. Lafayette Blvd.
Bechtold, Samuel E. 730 J M S Bldg.
Berke, Robert D. Healthwin Hospital
Bickel, David A. 515 Odd Fellows Bldg.
Birmingham, Peter J. 426 Sherland Bldg.
Bishop, Charles A. 120 N. Lafayette Blvd.
Bixler, Louis C. 615 Sherland Bldg.
Blackburn, Erwin 508 Sherland Bldg.
Bolka, Bernard J. 714 W. Washington Ave.
Boone, John C. (H) ..R. R. 4, Box 537, Auten Rd.
Bosenbury, Charles S. 604 N. Main St.
Braunsdorf, Robert L. 514 Sherland Bldg.
Buchanan, Wallace D. 825 Sherland Bldg.
Buechner, Frederick W. 116 N. Main St.
Bussard, Clifford F. 538 Associates Bldg.
Carter, F. R. N. 605 Sherland Bldg.
Cassady, James V. 525 Sherland Bldg.
Caton, Joseph R. 1123 Niles Ave.
Clapp, Fred R. 120 N. Lafayette Blvd.
Clark, Stanley A. 615 Sherland Bldg.
Clark, William H. 120 N. Lafayette Blvd.
Colip, George D. 410 Sherland Bldg.
Condit, David H. 120 N. Lafayette Blvd.
Cooper, Harry L. 410 Sherland Bldg.
Culbertson, Carl S. 531 N. Main St.
Custer, Edward E. Healthwin Sanitarium
Dietl, Ernest L. 527 Sherland Bldg.
Duggan, James A. 316 St. Joseph Bank Bldg.
Dunlap, D. Logan 409 J M S Bldg.
Edwards, Bernard E. 226 Sherland Bldg.
Ellison, Alfred H. 826 Sherland Bldg.
English, John P. 120 N. Lafayette Blvd.
Ericksen, Lester G. 615 Sherland Bldg.
Faltin, Ladislaus 607 Odd Fellows Bldg.
Farnham, Waldo C. 408 W. Wayne St.
Filipek, Walter J. 311 Odd Fellow Bldg.
Firestein, Ben Z. 317 Odd Fellow Bldg.
Firestein, Ray 3201 Mishawaka Ave.
Fish, Clyde M. 723 Sherland Bldg.
Fish, Edson C. 401 N. Notre Dame Ave.
Fisher, Lawrence F. 825 Sherland Bldg.
Frank, Lyall L. 224 W. Navarre
Frash, DeVon W. 1910 Miami St.
Frith, Gladys 521 W. Washington St.
Frith, Louis G. 521 W. Washington St.
Gates, George E. 120 N. Lafayette Blvd.
Gilman, Marcus M. 403 Odd Fellow Bldg.
Gillespie, Chauncey M. 1240 Lincolnway, W.
Giordano, Alfred S. 531 N. Main St.
Goraczewski, Thaddeus C. .1016 W. Washington Ave.
Gordon, Joshua M. 726 J M S Bldg.
Green, George F. 506 Sherland Bldg.
Grillo, Donald 530 Sherland Bldg.
Haley, Paul E. 401 Sherland Bldg.
Harmon, Vachelle E. 302 Sherland Bldg.
Haymond, Joseph L. 531 North Main St.
Helmen, Harry W. 120 Franklin Place
Hewitt, Marshall I. 315 Sherland Bldg.
Hilbert, John W. 410 W. Washington Ave.
Hillman, Marion W. 429 Sherland Bldg.
Hillman, William H. 429 Sherland Bldg.
Hoffman, Robert V. 416 Sherland Bldg.
Holdeman, Lillian Scheib. 404 N. Lafayette
Holdeman, Richard W. 404 N. Lafayette
Huffman, Albert D. 718 Sherland Bldg.
Hyde, Carroll C. 120 N. Lafayette
Kamm, Bernard A. 526 Sherland Bldg.
Klahr, Elsworth E. 706 Odd Fellow Bldg.
Knapp, Arthur L. 2215 Mishawaka Ave.
Knode, Kenneth T. 729 Sherland Bldg.
Kramer, Albert A. 1519 Miami St.
Lane, William H. 604 N. Main St.
Lang, Joseph E. 730 J M S Bldg.
Langenbahn, Carl J. 206 Sherland Bldg.
Liss, Emanuel C. 317 Odd Fellow Bldg.
Malstaff, Comiel M. 1654 Portage Ave.
Mason, Bernard A. 120 N. Lafayette Blvd.
McCraley, William J. 406 Sherland Bldg.
McDonald, Ralph M. 619 J M S Bldg.
McFarland, Corley B. 120 N. Lafayette Blvd.
McKenna, Henry J. ..Bendix Corp., Medical Dept.
McMeel, James E. 514 Associates Bldg.
Metcalfe, Grant E. 319 Odd Fellow Bldg.
Mikesch, William H. 816 Sherland Bldg.
Miller, Milo K. 120 N. Lafayette Blvd.
Miller, William E. 714 W. Washington
Mitchell, Harry F. (H) 928 Riverside Drive
Mott, Cassell A. 1301½ W. Washington St.
Murphy, Eugene C. 120 N. Lafayette Blvd.
Murphy, Josephine F. 625 J M S Bldg.
Nelson, F. Dale 428 Sherland Bldg.
Nelson, Raymond E. 510 Sherland Bldg.
Olson, Kenneth L. 615 Sherland Bldg.
Pauszek, Thomas B. 546 Associates Bldg.
Petrass, Andrew 516 Sherland Bldg.
Plain, George 120 N. Lafayette Blvd.
Proudfit, Charles H. 515 Odd Fellow Bldg.
Pyle, Harold D. 518 Sherland Bldg.
Rasmussen, Ruth F. 120 N. Lafayette Blvd.
Rigley, Edward L. 406 Sherland Bldg.
Rodin, Herman H. 422 Sherland Bldg.
Rosenheimer, George M. Memorial Hospital
Rubens, Eli 201 Christman Bldg.
Rudolph, Carl J. 716 J M S Bldg.
Rustin, Edward I. St. Joseph Hospital
Sanderson, Robert B. 730 Sherland Bldg.
Sandock, Isadore 402 Sherland Bldg.
Sandock, Louis F. 301 Sunnyside Ave.
Sandoz, Harry H. 239 Hawthorne Dr.
Sandoz, Louis A. 720 Sherland Bldg.
Savery, Charles E. 230 Sherland Bldg.
Schiller, Herbert A. 510 Sherland Bldg.
Scott, Frank M. 120 N. Lafayette Blvd.
Selby, Keith E. 407 Lincolnway, W.
Sennett, Cecil M. 318 Sherland Bldg.
Sensenich, R. L. 203 J M S Bldg.
Skillern, Penn G. 1002 Building and Loan Tower
Slominski, Harry H. 708 Odd Fellow Bldg.
Spenner, Raymond W. 726 Sherland Bldg.
Stiver, Daniel D. 528 Sherland Bldg.
Terry, Charles C. Mar-Main Apts.
Thornton, Maurice J. 825 Sherland Bldg.
Traver, Perry C. 1010 Riverside Dr.
Wegner, William G. 534 Associates Bldg.
Weiss, Eugene 2521 S. Michigan St.
Wilhelm, Agatha M. 628 Sherland Bldg.
Wilson, James L. 617 J M S Bldg.
Linton, Charles D. Walkerton
Fisher, Kenneth 251 Sinclair Ave., Glendale 6, Calif.
Boyd-Snee, Harry (H) ..4353 W. 5th St., Apt. D, Los Angeles, Calif.
Libnoch, Casimir L. ..2965 Lawndale, Chicago, Ill.
Darling, Dorothy R., Patton Hall, Evanston Hosp., Evanston, Ill.
Grzesk, Leo L. Granite City, Ill.
Houser, Alan D. Mohonk Mountain House, Mohonk Lake, N. Y.
Evers, Raymond H. Lakeview Hospital, Madison, Wis.

SCOTT COUNTY

Bogardus, Carl R. Austin
Fitzpatrick, James S. Scottsburg
Hill, Thomas N. Scottsburg
McClain, Marvin L. Scottsburg
Napper, Floyd S. Scottsburg
Wilson, Joseph P. (H) Scottsburg

SHELBY COUNTY

Nigh, Rufus M. Fairland
Davis, John A. Flat Rock
Nave, H. E. Fountaintown
Patten, Vernon C. Morristown

SHELBY COUNTY—(Cont.)

Shelbyville

Barnum, Emerson Methodist Bldg.
Bass, Frank E. 10 S. West St.
Billman, Gustus S. R.R. 2
Coomes, M. Joseph Shelbyville
Gehres, Robert W. 15 S. Tompkins
Grove, Emil G. 234 W. Jackson St.
Inlow, Charles F. 131 W. Washington St.
Inlow, Herbert H. 131 W. Washington St.
Inlow, William D. 131 W. Washington St.
Kennedy, Samuel (H) 131 E. Franklin St.
Miller, Richard C. 17 Mechanic St.
Mohr, Ann L. Shelbyville
Richard, Norman F. Inlow Clinic
Scott, V. Brown Inlow Clinic
Silbert, Davis B. 17 S. Tompkins
Tindall, Paul R. 20 N. Pike St.
Tindall, William R. 616 S. Harrison St.
Coulson, Sewell B. Waldron
Keeling, James E. (H) Waldron
Hulsman, Louis F. Kadlec Hospital, Richmond, Wash.

SPENCER COUNTY

Springston, Charles L. Chrisney
Barrow, John H. Dale
Medcalf, Norman L. Lamar
Jolly, Parvin W. Richland
Atchison, Kenneth C. Rockport
Ehrman, Calder D. Rockport
Glackman, John C. Rockport

STARKE COUNTY

DeNant, James L. Hamlet
DeNant, James F. Knox
Ingwell, Guy B. Knox
Farabee, Charles R. North Judson
Fisher, Albert North Judson

STEUBEN COUNTY

Creel, Donald W. Angola
Crum, Marion M. Angola
Eberhart, Lester L. Angola
Kissinger, Knight L. Angola
Lane, William H. (H) Angola
Waller, William F. Angola
Blosser, Blaine A. Fremont
Hippensteele, Ralph O. Fremont
Denman, Robert D. Helmer
Lake, George N. Pleasant Lake

SULLIVAN COUNTY

Brown, John S. Carlisle
Whipps, Charles E. Carlisle
Deputy, Ernest M. Dugger
Dukes, Frederic M. Dugger
Bland, Herbert E. Fairbanks
O'Dell, Harry C. Farmersburg
Oliphant, Jacob T. Farmersburg
Zerfas, Leon G. Merom
Hamilton, Anthu Ann Shelburn
Bedwell, Marion H. Sullivan
Briggs, Carl F. Sullivan
Crowder, James H., Jr. Sullivan
Donnelly, Robert W. Sullivan
Higbee, Paul Sullivan
Maple, James B. Sullivan
Scott, Garland D. Sullivan
Scott, Irvin H. Sullivan
O'Dell, Harry W. Medical Center, Staff House, Jersey City, N. J.

SWITZERLAND COUNTY

Bear, Lowery H. (H) Vevay
Copeland, George W. Vevay
Ellerbrook, George E. Vevay
King, Jack A. C. Vevay
Zink, Robert O. Vevay

TIPPECANOE COUNTY

Wagoner, Robert H. Colburn
Hamilton, Eugene E. Dayton

Lafayette

Ade, Charles H. Lafayette Life Bldg.
Ade, Mary K. Lafayette Life Bldg.
Arnett, Arett C. 8th and Ferry Sts.
Bauer, Arthur J. 112 N. 7th St.
Bayley, Richard H. M. 8th and Ferry Sts.
Buhrmester, Harry C., Jr. 308 N. 8th St.
Burkle, John C. 133 N. 4th St.
Calvert, Raymond R. 314 N. 6th St.
Cole, Ira 2315 South St.
Cox, Wayne T. 206-7 Schultz Bldg.
Coyner, Alfred B. 815-16 Lafayette Life Bldg.
Crockett, Franklin S. 724 Lafayette Life Bldg.
Dewey, George W. Soldiers' Home
Donahue, George R. Lafayette Life Bldg.
DuBois, Ramon B. 516 Main St.
Eaton, Marion J. Lafayette Life Bldg.
Engeler, James E. 308 N. 8th St.
Flack, Russell A. 217 N. 6th St.
Frasch, Mahlon G. Lafayette Life Bldg.
Gery, Richard E. 8th and Ferry Sts.
Graham, Thomas G. 11 N. 24th St.
Griest, Oliver E. Lafayette Life Bldg.
Harris, Lloyd E. 21 N. 24th St.
Herrold, George W. Lafayette Life Bldg.
Holladay, Lloyd J. Lafayette Life Bldg.
Hunter, Frank P. Lafayette Life Bldg.
Hupe, Charles (H) 212 N. 8th St.
Ikins, Ray G. 605 S. 7th St.
Klepinger, Harry E. 824 Lafayette Life Bldg.
Laws, Harry J. Lafayette Life Bldg.
Laws, Kenneth F. Address Unknown
Leak, Robert H. 417 Ferry St.
Levering, Guy P. 616 Columbia St.
Loop, Floyd A. Lafayette Life Bldg.
Loop, Frederick A. Lafayette Life Bldg.
McClelland, Donald C. 8th and Ferry Sts.
McFadden, James M. St. Elizabeth Hospital
McKinley, Joseph St. Elizabeth Hospital
McKinney, Daniel H. Lafayette Life Bldg.
Marsh, George W. 1405 N. 14th St.
Martin, Harold G. 417 Ferry St.
Martin, Harold R. St. Elizabeth Hospital
Martin, Joe M. St. Elizabeth Hospital
Morrison, John S. (H) Lafayette Life Bldg.
Neumann, Kenneth O. 11 N. 24th St.
Pearlman, Samuel S. 107 N. 6th St.
Peterson, Joel A. 609 Lafayette Life Bldg.
Peyton, Frank W. 11 N. 24th St.
Ratcliff, Frank W. 300 Main St.
Romberger, Floyd T. 521 Lafayette Life Bldg.
Ruschli, Edward B. Lafayette Life Bldg.
Shafer, John W. Lafayette Life Bldg.
Shotts, Lloyd O. 631 Columbia St.
Shotts, William M. 631 Columbia St.
Smith, Lowell C. 405 Schultz Bldg.
Smith, Marsh H. 707 Hayes St., West Lafayette
Stahl, Edward T. 8th and Ferry Sts.
Stoen, Harold J. Lafayette Life Bldg.
Straver, Joseph W. 612 Lafayette Life Bldg.
Swezey, Harry N. Lafayette Life Bldg.
Thomas, Gordon A. 608 Columbia St.
Trout, Carl J. 314 N. 6th St.
Tubbs, George R. 608 Columbia St.
VanBuskirk, Edmund L. 8th and Ferry Sts.
Washburn, Will W. 8th and Ferry Sts.
Wray, Curtis M. 110 N. 7th St.
McCay, Ora L. Romney
Mitchell, Edgar T. Romney
Ash, Harold H. West Lafayette
Meikle, Louise J. West Lafayette
Miller, Sayers J. West Lafayette
Romel, Clarence H. West Lafayette
Rose, Bertha West Lafayette
Schmiedicke, Paul H. West Lafayette
Yonman, Tom 326 Northwestern Ave., West Lafayette
Harvey, Bernard J. 3544 W. 101th Pl., Inglewood, Calif.
Randall, Karl C. H. 305 Wilson Ave., Washington, Pa

TIPTON COUNTY

Cotton, Stanley M. Goldsmith
Dunham, Wilbur F. Kempton
Stouder, Albert E. Kempton
Tranter, William F. Sharpsville
Burkhardt, Boyd A. Tipton
Carter, Jean V. Tipton
Connoy, Leo F. Tipton
Kurtz, William A. Tipton
Overman, Frederick V. Tipton
Warne, George H. Tipton
Erieson, Harold L. Windfall
Moser, Elmer B. Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

Aere, Robert R. 617 Hulman Bldg.
Adler, Raymond N. 714 2nd St.
Alexander, John E. 609 Hulman Bldg.
Allenbaugh, Arleigh E. American Trust Bldg.
Anderson, Dwight W. 814 N. Main St.
Antes, Earl H. 412 S. E. 4th St.
Baker, Clarence S. 109½ S. E. 3rd St.
Baker, Herman M. 402 Hulman Bldg.
Baker, James S. 407 Metro Bank Bldg.
Barclay, Irvin C. 114 S. E. 2nd St.
Beeler, Bruce H. 301 3rd and Main Bldg.
Boyd, Stella N. B. 502 Hulman Bldg.
Brown, Robert L. 629½ Main St.
Bryan, Stanton L. 902 Hulman Bldg.
Buikstra Cyrus R. 609 Hulman Bldg.
Cacia, John J. 609 Hulman Bldg.
Caldwell, William C. 504 Old National Bank
Clements, Albert F. 15 S. E. 2nd St.
Cockrum, William M. 908 Hulman Bldg.
Cody, Burtis L. 204 Boehne Bldg.
Cole, William L. 1338 Division St.
Coleman, Walter H. 322 N. Fulton Ave.
Combs, Herman T. 807 W. Indiana
Combs, John H. 412 S. E. 4th St.
Combs, Pearl B. 1623 Lincoln Ave.
Conover, Earl 110 S. E. 2nd St.
Corcoran, Patrick J. V. 118 S. 1st St.
Crane, Albert L. R. R. 7, Box 837
Crimm, Paul D. Boehne Hospital
Culhane, Chris W. 2312 W. Franklin St.
Daves, William L. 608 Old National Bank Bldg.
Davidson, William D. 306 American Bank Bldg.
Davidson, William R. 308 American Trust Bldg.
Denzer, Edward K. 108 S. E. 2nd St.
Denzer, William Oliver 108 S. E. 2nd St.
Dieckman, Herbert S. 1012 Citizens Bank Bldg.
Diefendorf, Charles F. 2413 W. Franklin St.
Dobbins, Thomas 119 N. Morton St.
Dodd, Robert K. 819 W. Franklin St.
Durkee, Melvin S. 306 Citizens Nat. Bank Bldg.
Dycus, Walter A. 2200 W. Franklin St.
Ehrich, William S. 808 Old National Bank Bldg.
Eichelberger, William W. State Hospital
Eisterhold, John A. 220 S. E. Riverside Dr.
Engel, Edgar L. 15 S. E. 7th St.
Faul, Henry J. 815 Hulman Bldg.
Fickas, Dallas 619 Mary St.
Fitzsimmons, Elvin Lee Sycamore and 6th Sts.
Folz, Charles J. 2A S. E. 5th St.
French, William G. Station D, Box 2036
Fritsch, Louis E. 30 W. Franklin St.
Garland, Edgar A. 646 S. Weinbach Ave.
Gaul, LaVerne E. 509 Hulman Bldg.
Grosskreutz, Doris 705 Main St.
Hare, John H. Woodmere Hospital
Harris, William Lee 115 S. E. 6th St.
Hart, L. Paul 207 S. E. 1st St.
Hartley, Clarence A., Jr. 126 Locust St.
Hartley, C. A., Sr. 417 Peoples Savings Bank Bldg.
Hartz, F. Minton 23 S. E. 2nd St.
Healy, William F. 607 Hulman Bldg.
Heard, Albert 322 E. Cherry St.
Heberer, Joseph M. 1111 W. Columbia St.
Hefti, Karl R. 125 S. E. 2nd St.
Helper, Morton 219 Walnut St.
Herzer, Clarence C. 412 Hulman Bldg.
Hewins, Warren W. 912 Hulman Bldg.
Hoopes, Jane M. 125 S. E. 2nd St.
Huggins, Victor S. 604 Citizens Nat. Bank. Bldg.
Jerome, Joseph N. (H) 703 S. E. 2nd St.
Johnson, Gardner C. 212 American Trust Bldg.
Johnson, Stephen L. 6th and Sycamore Sts.
Kauffman, Harley M. 219 Walnut St.
King, Everett A. 701 Court St.
Kleindorfer, Roscoe L. 819 W. Franklin St.
Lang, Shirley C. 957 S. Kentucky Ave.
Laubseher, Clarence Kratzville Rd.
Laval, William J. (H) 616 S. E. 1st St.
Lawrence, Joseph C. 700 Mary St.
Leich, Charles F. 124 S. E. 1st St.
Leslie, Ermil T. 629½ Main St.
Logan, Jesse R. 419 Edgar

VANDERBURGH COUNTY—(Cont.)

Evansville

Lynch, Harold D.....216 S. E. Riverside Dr.
Lynch, Paul V.....216 S. E. Riverside Dr.
McCool, Joe H.....1308 N. Main St.
McCool, William E. (H).....R. R. 5, Box 452
McDonald, Joseph D.....6th and Sycamore Sts.
Macer, Clarence G.....411 Hulman Bldg.
MacKenzie, Pierce.....17 S. E. 7th St.
Mackey, John E.....227 S. Grand Ave.
Mason, Everett E.....936 Central Union Bk. Bldg.
Mehl, Rudolph A.....752 S. 8th St.
Meyer, Keith T.....118 S. 1st St.
Miller, LaVerne B.....714 N. Main St.
Miller, Milton.....103 N. Main St.
Miller, Minor.....Court House Annex
Miller, Robert J.....1905 Division St.
Mino, Victor H.....123 Mary St.
Moehlenkamp, Charles E.....614 N. Governor St.
Muelchi, Adeline F.....518 Hulman Bldg.
Nemneker, Henry Harmonyway
Newman, Alvin E.....912 Hulman Bldg.
Niedermayer, Alfred J..Welborn Baptist Mem. Hosp.
Nisenbaum, Harold.....704 Hulman Bldg.
Oliver, Elbert W.....20 E. Oregon St.
Oppenheimer, Ernest.....103 S. E. 2nd St.
Pollard, Walter S.....115 S. E. 2nd St.
Present, Julian.....2nd and Main Sts.
Pugh, Willis.....700 Mary St.
Raphael, Isidor J.....617 Hulman Bldg.
Ratcliffe, Albert W.....St. Mary's Hospital
Ravdin, Bernard D.....712 Hulman Bldg.
Ravdin, Marcus (H).....712 Hulman Bldg.
Reich, Clarence E.....1209 N. Fulton St.
Reitz, Thomas F.....636 Sunset
Rich, James S.....412 S. E. 4th St.
Richey, Clifford O.....860 Washington Ave.
Ritz, Albert S.....402 Old National Bank Bldg.
Robinson, Earl U.....615 Bellemeade
Rosenblatt, Bernard B.....709 Hulman Bldg.
Rossow, Russell J.....Walker-Welborn Hospital
Royster, George M.....810 Citizens Bank Bldg.
Royster, Robert A.....412 S. E. 4th St.
Ruddick, Hobard C.....816 Hulman Bldg.
Scales, Alfred B.....1161 S. E. 2nd St.
Schirmer, Robert H.....2005 W. Franklin
Schneider, Charles P.....2211 W. Franklin St.
Schriefer, Victor V.....1307 Stringtown Road
Slaughter, Howard C.....909 Hulman Bldg.
Springstun, Walter R.....902 Hulman Bldg.
Stork, Urban.....412 S. E. 4th St.
Sutter, Charles C.....1311 Cumberland Ave.
Taylor, Eugene C.....853 Lincoln Ave.
Tweedall, Daniel G.....2114 W. Franklin St.
Underwood, Gordon B.....539 Hulman Bldg.
Viehe, Robert W.....207 S. E. 1st St.
Visher, John W.....834 Old National Bank Bldg.
Watson, Herman L.....612 S. Weinbach Ave.
Weber, Edgar H.....123 S. E. 2nd St.
Weiss, Henry G.....614 Hulman Bldg.
Welborn, James Y.....412 S. E. 4th St.
Welborn, Mell B.....412 S. E. 4th St.
Wesson, Thomas W.....124 S. E. 1st St.
Willis, Charles F.....1100 S. Bedford
Willis, Joseph H.....947 S. E. 8th St.
Willison, George W.....118 S. E. 1st St.
Wilson, Ralph.....804 Washington Ave.
Wishart, Shelby W.....216 3rd & Main St. Bldg.
Wood, William H.....1651½ Lincoln Ave.
Wyatt, Fred H.....122 Locust
Wynn, Justice F.....906 Hulman Bldg.
Yeck, Charles W.....115 S. E. 6th St.
Yunker, Philip E.....910 Hulman Bldg.
Zimmerman, Harold.....6 S. E. 2nd St.
Wilhelmus, William M.....Saint Wendell
Morgan, M. M...2218 Market St., Youngstown, O.
McMurtry, L. K...Box 126, Corpus Christie, Texas

VERMILLION COUNTY (See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
Bland, Curtis Oaktown
French, Virgil W.....Riley
Silverman, Norman M.....Riley
Carmichael, Clyde S.....Seelyville

Terre Haute

Alexander, Oliver O.....301 Rose Dispensary Bldg.
Allen, Orris T.....422 Rose Dispensary Bldg.
Anderson, Walter C.....721 Wabash Ave.
Asbury, William D.....222 Rose Dispensary Bldg.
Baldridge, Ezra R.....321 Rose Dispensary Bldg
Baldridge, William O...12 Points State Bank Bldg.
Bernheimer, Herman L. (H).....506 Ohio St.
Blum, Leon L.....221 S. Sixth St.
Bopp, Henry W.....521 Grand Opera House Block
Bradley, Stephen C.....221 S. Sixth St.
Bronson, Paul J.....721 Wabash Ave.
Brown, Robert R.....221 S. Sixth St.
Cabell, Abram L. (H).....16 White Block
Carpenter, George C.....410 Ohio St.
Cavins, Alexander W.....221 S. Sixth St.
Combs, Charles N Union Hospital
Combs, Stuart R 505 Tribune Bldg.
Congleton, Geo. C...308 Merchants Nat. Bank Bldg
Connelly, John J.....Rose Dispensary Bldg.
Connerley, Marion L.....2206 College Ave.
Crawford, William G.....221 S. Sixth St.
Curry, Claude A.....506 Rose Dispensary Bldg.
Dailey, John E.....1232 Wabash Ave.
Decker, Harvey B.....202 Rea Bldg
Dyer, George W.....208 Rose Dispensary Bldg.
Eisenlohr, Eugen.....300 S. Sixth St.
Forsyth, David H...215 Merchant's Nat. Bank Bldg.
Freed, John E.....414 Rose Dispensary Bldg.
Freed, John E., Jr.....2408 N. Tenth St.
Fuqua, Harold B 314 Opera House Bldg
Gerrish, Donald A.....Rose Dispensary Bldg.
Gilbert, Ivan.....505 Rose Dispensary Bldg.
Gillum, John R.....221 S. Sixth St.
Goodman, Hubert T.....310 Opera House Bldg.
Harkness, Robert G.....301 Rose Dispensary Bldg.
Haslem, Ezra R.....401 Rose Dispensary Bldg.
Haslem, John R.....221 S. Sixth St.
Hoover, Dewey A.....14½ N. Third St.
Hoover, James J.....14½ N. Third St.
Hunt, Edgar J.....208 Rose Dispensary Bldg.
Hunt, William B, (H).....R. R. No. 3
Hutchings, Byron M.....641 Ohio St
Kreible, William W.....221 S. Sixth St.
Kunkler, Joseph.....408 Chestnut St.
Kunkler, William C.....212 Merchant's Bank Bldg.
LaBier, Clarence Rollin..408 Rose Dispensary Bldg.
LaBier, C. R., Jr.....408 Rose Dispensary Bldg.
Lee, Allen H.....502 Tribune Bldg
Loewenstein, Werner L.....1421 S. Seventh St.
Love, John R.....1601 Eighth Ave.
McBride, Earl C.....1630 Wabash Ave.
McBride, Noel S ..407 Merchant's Nat. Bank Bldg.
McCarthy, Frank G.....721 Wabash Ave.
McCormick, Wilbur C...312 Merchant's Bank Bldg.
McEwen, James W.....321 Rose Dispensary Bldg.
McLaughlin, Gordon C.....501 Tribune Bldg.
Mahoney, Charles L.....221 S. Sixth St.
Malone, Leander A 721 Wabash Ave.
Mattox, Don M.....721 Wabash Ave.
Miller, Daniel B 1603 S. Seventh St.
Mitchell, Albert M.....503 Tribune Bldg
Mullikin, Hugh M.....202 Rose Dispensary Bldg.
Musselman, Glen G 1229 Maple Ave
Nav, Ernest O.....221 S. Sixth St.
Niblack, Earl S. (H).....620 Tribune Bldg.
Oliphant, Robert W.....420 Tribune Bldg.
Pierce, Harold J 627 Cherry St.
Richart, James V.....414 Rose Dispensary Bldg.
Riggs, Floyd C.....Indiana State Teachers College
Rubin, Milton M.....Tribune Bldg.
Sayers, Frank E 507 Rose Dispensary Bldg.
Schott, Edward J.....Merchant's Nat. Bank Bldg.
Schumaker, Robert A.....211 Fairbanks Bldg.
Selsam, Etta....203 Merchant's Nat. Bank Bldg
Shanklin, Vernon A.....208 Fairbanks Bldg.
Siebenmorgan, Louis.....Terre Haute Bank Bldg.
Sloss, Imit H.....417½ Wabash Ave.
Smoots, Samuel A.....1307 Maple Ave.
Spigler, James F...314 Merchant's Nat. Bank Bldg.
Stewart, Walter E.....721 Wabash Ave.
Strong, Daniel S.....R. R. No. 7, Box 170
Sullivan, John M.....2242 College
Topping, Malachi C.....Tribune Building
Utterback, Arnold..603 Merchant's Nat. Bank Bldg.
VanArsdall, Clarence R.....17 S. Ninth St.
Vandivier, Henry R.....210 Rose Dispensary Bldg.
Voges, Edward C.....1402 Wabash Ave.
Weber, Joseph G. S.....721 Wabash Ave.
Weinstein, Joseph H.....221 S. Sixth St.
White, James V.....1609 S. 20th St.
Wiedemann, Frank E...222 Rose Dispensary Bldg.
Wilson, Fred L.....1501 South Third St.
Wilson, John R.....1501 South Third St.
Wyeth, Charles (H).....1400 S. Seventh St.
Yung, Julius R.....Rose Dispensary Bldg.
Zwerner, Paul F.....1252½ Maple Ave.
Knoefel, Peter K.....101 W. Chestnut St., Louisville, Ky.
Luckett, Coen L.....Bradford, Pa.

WABASH COUNTY

Walker, James L.....LaFontaine
Balsbaugh, George North Manchester
Brubaker, O. G.....North Manchester
Bunker, Ladoska Z.....North Manchester
Cook, Charles E.....North Manchester
Parker, Horace P.....North Manchester
Seward, George W.....North Manchester
Venable, George L North Manchester
Warvel, Joseph L. (H).....North Manchester
Kidd, James G.....Roann
Black, Edgar K.....Wabash
Flinn-Jordan, Minnetta Wabash
LaSalle, Robert M.....Wabash
Mills, John F.....Wabash
Naugle, Raymond A.....Wabash
Pearson, William E.....Wabash
Rhamy, Arthur P.....Wabash
Steffen, Arthur J. Wabash
Steffen, Julius T. Wabash
Stoops, Jean T.....Wabash
Thompson, Noah H. (H).....Wabash
Wall, Joseph A.....Wabash
Whisler, Frederick M.....Wabash
Siegelmileh, Lorin.....3708 Falcon Ave., Long Beach, Calif.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Hoover, J. Guy Boonville
Hoover, Peter B. Boonville
Loomis, DeWitt Boonville
Samples, John T.....Boonville
Stover, Wendell C.....Boonville
Wilson, Paul E.....Boonville
Taylor, Lon S.....Elberfeld
Wilhelmus, Charles K.....Newburgh
Wilhelmus, Charles M.....Newburgh
Zwickel, Ralph E.....Newburgh
Springstun, Charles E.....Tennyson
Luckett, Charles L.....507 Hooker-Fulton Bldg., Bradford, Pa.
Susott, Kathryn C.....Tokyo, Japan

WASHINGTON COUNTY

Tower, Thomas K.....Campbellsburg
Green, William L.....Pekin
Allen, Fred K.....Salem
Episcopo, A. R.....Salem
Gilliatt, James P.....Salem
Huekleberry, Irvin E.....Salem
Mitchell, John L.....Salem
Paynter, Lawrence W.....Salem
Mull, Philip L.....Box 1432, Louisville, Ky.

WAYNE-UNION COUNTIES

Clark, Marion E.....Cambridge City
Hill, Paul G.....Cambridge City
Kenyon, Charles E.....Cambridge City
Study, Joseph N. (H).....Cambridge City
Barton, Willoughby M.....Centerville
Bartlett, Robert C.....Dublin
Lutes, David L.....Dublin
McKee, Charles E. (H).....Dublin
Marsh, Chester A.....Hagerstown
Miller, William A Hagerstown
DuBois, Franklin T. (H).....Liberty
Lewis, James F.....Liberty
McWilliams, William B.....Liberty
Thompson, Will A.....Liberty
Faucett, Ralph E.....Pershing

WAYNE-UNION COUNTIES—(Cont.)

Richmond

Ake, Loren....1707 E. Main St.
Allen, Hubert E....21 S. 8th St.
Allen, Robert T....21 S. 8th St.
Ballenger, William E....309 Medical Arts Bldg.
Blossom, Paul W....825 S. A St.
Bond, Charles S. (H)....112 N. Tenth St.
Buche, Frederick P....106 S. Seventh St.
Campbell, Perry A....122 Medical Arts Bldg.
Clawson, Joseph C....36 S. 8th St.
Coble, Frank H....51 S. 8th St.
Cox, Leon T....36 S. 8th St.
Denny, Edgar C....Richmond State Hospital
Dingle, Paul E....403 Medical Arts Bldg.
Griffis, Vierl C....208 Medical Arts Bldg.
Hadley, Harvey....First National Bank Bldg.
Hagie, Franklin E..407 Second National Bank Bldg.
Harmon, Carl J....407 Medical Arts Bldg.
Harmon, Gladys H....407 Medical Arts Bldg.
Hays, George R...401 Second National Bank Bldg.
Hill, Harold D....412 Medical Arts Bldg.
Hoffman, Curtis R...405 First National Bank Bldg.
Holland, Emory E....1907 E. Main St.
Hufnagel, Chas. A ..516 First National Bank Bldg.
Hunt, Gayle J....130 Medical Arts Bldg.
Johnson, Paul S....215 Medical Arts Bldg.
Kinsey, Joseph H....124 N. Eighth St.
Krueger, Frederick W....45 S. Seventh St.
Lee, Glen W....139 Medical Arts Bldg.
Logan, James Z....203 Second Nat. Bank Bldg.
Lynch, Otho R....Richmond State Hospital
Malcolm, Russell....127 Medical Arts Bldg.
Meredith, Elwood J....203 Medical Arts Bldg.
O'Hale, John A....Smith-Esteb Hospital
Pentecost, Paul S....98 W. Main St.
Poston, Clement L..406 First National Bank Bldg.
Ross, Harry P....410 Second National Bank Bldg.
Ross, Louis F....308 Second National Bank Bldg.
Snyder, Morris C....130 Medical Arts Bldg.
Stamper, Lucian A....202 Medical Arts Bldg.
Sweet, Howard E....401 Medical Arts Bldg.
Taylor, William R....308 Medical Arts Bldg.
Vance, William C....136 Medical Arts Bldg.
Wanninger, Horace....408 2nd Nat. Bank Bldg.
Weinstein, Edwin B....204 Colonial Bldg.
Whallon, Arthur J....29 S. Tenth St.
Wickens, Mary....Richmond State Hospital
Wisener, Guthrie H....213 Medical Arts Bldg.
Yencer, Martin W....22 N. Fourteenth St.
Shepard, Fred F....202 W. Liberty St., College Corner, Ohio
Porter, Wm. L....High & College Sts., Oxford, O.
Hiatt, Russell....Vet. Administration, Chicago, Ill.

WELLS COUNTY

Bluffton

Annis, Homer B....303 S. Main St.
Buckner, Joy F....Bluffton
Brickley, Harry D....227 S. Main St.
Caylor, Harold D....303 S. Main St.
Caylor, T. E....303 S. Main St.
Chrispin, John W....303 S. Main St.
Cook, Robert G....303 S. Main St.
Dorrance, Thomas O....303 S. Main St.
Eisaman, Jack L....303 S. Main St.
Gitlin, Max M....121 E. Market St.
Gitlin, William A....121 E. Market St.
Hamilton, O. G....227 S. Main St.
Long, Leonard....303 S. Main St.
Mead, Clarence H....227 S. Main St.
Morris, George B....114 E. Walnut St.
Nickel, Allen....303 S. Main St.
Sherman, Robert M....303 S. Main St.
Smith, H. Brooks....303 S. Main St.
Yoder, Richard P....303 S. Main St.
Gingerick, Charles M....Liberty Center
Davidoff, Manuel A....Ossian
Hardin, Wayne E....Ossian
Faganz, C. N...Vet. Administration, Topeka, Kan.
Resch, Fred. A...60 Woodrow Ave., Youngstown, O.

WHITE COUNTY

Galbreth, Jesse P....Burnettsville
Derhammer, George L....Brookston
Netherton, Clyde R....Chalmers
Houser, Wayne W....Monon
McClure, Stanley E....Monon
Carney, John C....Monticello
Gable, Homer B....Monticello
Greist, H. W. (H)....Monticello
Hibner, Nolan....Monticello
Morris, Warren V....Monticello
Mayfield, Clifford H....Reynolds
Forbes, Violet M. Crabbe....Wolcott
Morrical, Russell J....Wolcott

WHITLEY COUNTY

Briggs, Jesse H....Churubusco
Hershey, Ernest A....Churubusco
Eisaman, Cecil....Columbia City
Heritier, Claude J....Columbia City
Lehmberg, Otto F....Columbia City
Leiter, Arthur....Columbia City
Linville, LeRoy....Columbia City
Nolt, Ernest V....Columbia City
Pence, Benjamin F....Columbia City
Wybourn, Robert....Columbia City
Garber, Paul A....South Whitley
Huffman, Verlin P....South Whitley

A.M.A. JOINS WORLD MEDICAL ASSOCIATION

The American Medical Association, by action of the Board of Trustees at its last meeting, has become a member of the "World Medical Association" — an organization which will promote the interchange of medical information among the medical associations of the world, according to an editorial in the October twenty-sixth issue of THE JOURNAL.

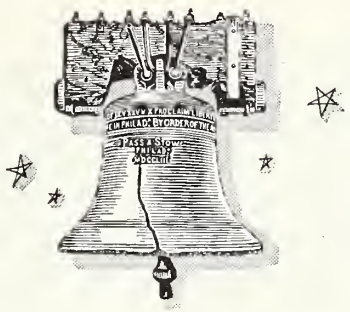
The editorial follows in full:

"At the end of September a conference met in London in which there were medical representatives of twenty-one European countries and ten countries outside Europe and at which the American Medical Association was represented by several observers appointed by the Board of Trustees. The meeting was held under the joint auspices of the British Medical Association, whose president, Sir Hugh Lett, presided, and the Association Professionelle Internationale des Médecins. The latter organization was an assemblage which was constituted before the war to give opportunity for interchange of medical information among the medical associations of the world regarding mutually interesting problems. The new conference agreed unanimously that an international organization of medical associations should be established and should limit itself to matters of medical practice and social medicine. The French, Belgian, Greek and Dutch delegates indicated that every country had its academies for promotion of medical science and that the immediate need was for an organization to defend the rights of the ordinary practitioner, especially in view of legislation passed in many countries. Dr. T. C. Routley, representing the Canadian Medical Association, indicated the desirability of an agency whereby the World Health Organization and UNESCO could make contacts with the medical associations of various countries. Ultimately the following platform was adopted for the new World Medical Association:

> To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available in order to assist all peoples of the world to attain the highest possible level of health; to study the professional problems which confront the profession; to organize an exchange of information on matters of interest to the profession, and to establish relations with, and to present the views of the medical profession to, the World Health Organization and the United Nations Educational, Scientific and Cultural Organization.

The members of the World Medical Association will be international medical associations representative of the medical profession in the country concerned. A subscription was fixed at 10 Swiss centimes per member for each national group up to a total of 10,000 members and 5 centimes per member above the first 10,000, with a maximum for any member association of 1,500 Swiss francs. Each member association will have two seats on the governing body. A professional committee of nine was established to draft a constitution and by-laws in French and in English to be submitted to the next conference, to be held in Paris. There are to be two secretaries for the World Medical Association, one in London and one in Paris. The American Medical Association, by action of the Board of Trustees at its last meeting, became a member of this organization."

THERE IS NO SUBSTITUTE FOR AMERICA!



"For what avail the plough or sail,
or land or life, if freedom fail?"

...EMERSON

★ A doctor told us, the other day, that he thinks of American freedom as a breathing organism. It can exhale benefits *for* our people no faster than it inhales contributions *from* our people.

He said:

"Take Medical Protective, for example. It wouldn't be able to offer doctors its fine service and protection against malpractice suits except for a freedom of enterprise which enabled it, first, to pioneer this specialized field—and then to broaden and perfect its service as its resources grew."

"But," he added, "companies like yours—and we doctors, too—are the *makers* of freedom as well as its *recipients;* for a government is less likely to encroach upon the liberties of a people who do not abuse them."

Through 1947, which will mark our 48th anniversary (a year for every star in the flag), our conviction that "there is no substitute for America" will remain firm.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE 2, INDIANA

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Medical Panorama by the ASSOCIATE EDITOR

MAINE MEDICAL ASSOCIATION is taking steps to establish a Prepaid Medical Care Plan. They also increased annual dues from $12.00 to $35.00. In addition, they are seeking the establishment of a medical school.

S
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MEDICAL SOCIETY OF NEW JERSEY has a full-time medical representative to the Veterans Administration Regional Headquarters; salary paid by V.A. through reimbursement to Medical Service Administration.

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HOUSE OF DELEGATES of the American Hospital Association heard about the subject of labor affiliations for nurses, and resolved that "in all matters the administration of hospitals stands as a representative of the general public."

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AMERICAN NURSES ASSOCIATION, through its House of Delegates, declared for "greater development of nurses' professional associations, as exclusive spokesmen for nurses in all questions affecting their employment and economic security."

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OHIO STATE MEDICAL JOURNAL makes a strong plea for members of the medical profession, as doctors and citizens, to "know about the activities of the various voluntary medical-health-welfare groups which are carrying on programs in your community."

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PERTINENT EXCERPTS from the News Letter, Council on Medical Service, A.M.A.:

1. "Briefing Clinic" for key speakers from medical societies brings big response. May require two or more sections.
2. Plans for formation of National Health Congress progressing.
3. California's seven Bay Area county societies embark on splendid, co-ordinating plan of public and professional relations.
4. Dauphin County (Pennsylvania) Society engages public relations firm to act as counsel in program of information to the public.
5. To cut down "too many meetings" and "too small an attendance," Greenville County (South Carolina) suggests combining several counties to meet at large central communities.
6. Something you didn't know. A.M.A., through Bureau of Medical Education, has sponsored television programs for a number of months.

A WESTERN COUNTY SOCIETY, through its officers, has the "effrontery" to complain about the lack of attendance at their meetings. Seems as though only 38 out of a membership of 665 showed up at a monthly meeting and, because too many left at the end of the scientific program, routine business could not be transacted for lack of a quorum. Ohio's State Journal in relaying this report says: "It was the first time in 27 years that such a situation had occurred." Unless and until the medical profession recognizes that its own salvation lies in *active support* and *honest work*, in the cause of organized medicine, from the county societies on up, and shows its interest—it is more than likely it will have a most unwelcome surprise in store. There is so much latent talent in the ranks of the medical profession that an earnest effort should be made, some way, some how, to bring it to the support of organized medicine in an effective way. The "effrontery" of the president of that local society, who complained about "A Sad State of Affairs," could, honestly, find echo and re-echo throughout the land. That boy had "guts!" May it bring results!

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STATE BOARD OF MEDICAL EXAMINERS have found, upon questioning, that there is an overwhelming preponderance of men, seeking license to practice, who are intent upon specialization. What's to become of the time-honored *specialty* of general practice? There have been many suggestions, none of which appeal to us as much as our own—the organization of a National Association of General Practitioners, and the establishment of a National Board of Certification in General Practice to bring the general man up to, and on an equal with, the assumed position of the specialist. Indiana has already taken the lead in this respect on a state level.

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MICHIGAN'S PUBLIC RELATIONS PROGRAM includes newspaper advertisements, sponsored by county societies, appearing in eighty daily and weekly papers; pamphlet distribution in the hundred thousand class; a radio program, "American Medicine," through fifteen stations; close cooperation with the Woman's Auxiliary; providing material for the debate subject of high schools, "Resolved: That the Federal Government Should Provide a System of Complete Medical Care Available To All Citizens At Public Expense"; a speakers' kit available to all county societies. This and much more under direction of a full-time Public Relations Council.



when constipation results from overstimulation

"Smoothage"—the term coined to describe the action of Searle Metamucil—seeks to avoid further irritation, to soothe and to protect the overstimulated intestinal mucosa, and to reestablish the normal reflexes of elimination.

Metamucil softens the fecal residue, affords bland bulk and exerts a gentle, stimulating, physiologic peristalsis.

METAMUCIL

is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

What's Going On In Indiana by the Executive Secretary

Radio Broadcast. Indiana medicine will be on the air Saturday afternon, January 25, 1947, on a 125-station coast-to-coast broadcast. The thirty-minute program is one of twenty-six being sponsored by the American Medical Association in connection with its centennial celebration this year. The broadcast will begin at 3 o'clock in the afternoon. The first twenty-five minutes will be a dramatization of the first cholecystotomy performed in America by Dr. Johns S. Bobbs in 1868. At that time he was president of the state medical association. At the conclusion of the dramatization the program will switch from Chicago to Indianapolis where Dr. Floyd T. Romberger, the president of the association, will be heard for three minutes. Dr. Charles N. Combs of Terre Haute supplied the historical material to the script writers, which was a tremendous time-consuming task. All physicians are urged to give publicity to this broadcast so there will be a large Hoosier listening audience.

———ISMA———

Signing Death Certificates. The law requires physicians to sign certificates of death, but in some communities a practice of other persons signing the physician's name has developed. This may be convenient, both for the funeral director and the doctor, but the certificate so signed is not legal and serious complications could arise therefrom. Health departments are within their legal rights in refusing to accept signatures by proxy. Funeral directors complain of time lost in trying to contact doctors to get signatures, and report that some physicians fail to co-operate with them. The executive committee recommends that doctors sign death certificates promptly and not let anybody else sign for them. In so doing, the doctor is fulfilling his legal obligation.

———ISMA———

A.M.A. Centennial Anniversary. The biggest A.M.A. meeting in the life time of any living physician will be held at Atlantic City, N.J., next June 9 to 13. It will be the Centennial Anniversary of the American Medical Association and will be marked by special features. Undoubtedly, a large number of Hoosier doctors will be going to this meeting. If you wish to attend, now is the time to make your hotel reservation! The headquarters office has sent each county medical society secretary a supply of blanks for use in applying for hotel rooms. Get one from your secretary today and mail it to the chairman of the Subcommittee on Hotels. Atlantic City has tremendous hotel facilities, to be sure, but the session is going to attract an extraordinary large crowd.

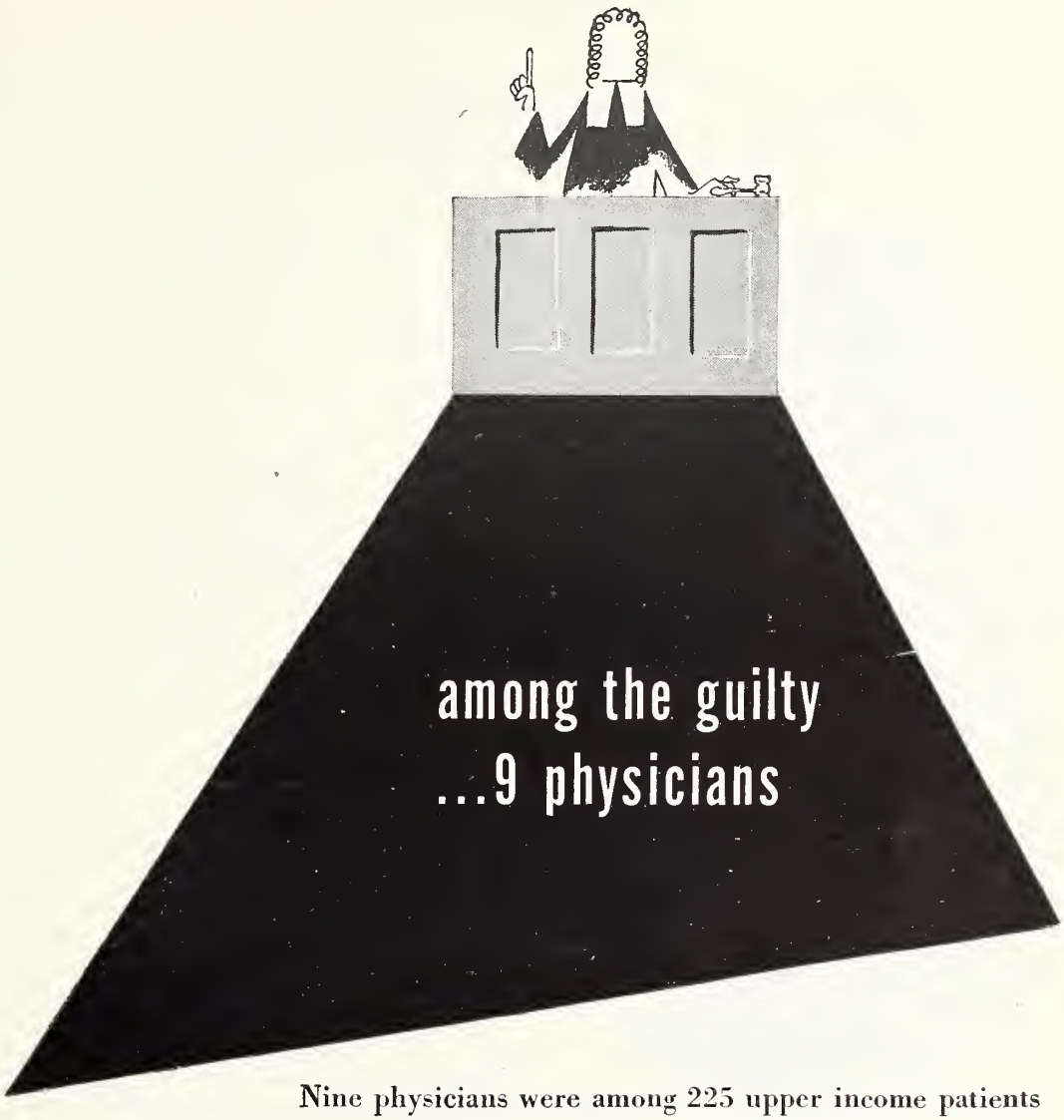
Novel Meeting Program. The LaPorte County Medical Society has a novel program arranged for its January meeting. The high school debating team has been invited to debate the 1946-47 subject of the Indiana Debating League: "Resolved, that the federal government should establish a system of complete medical care available to all citizens at public expense." Other societies wanting to hear the local high school debate team should contact the debate coach. Incidentally, why not supply the negative team with some sound arguments? If you do not know all the facts, ask the Council on Medical Service, 535 N. Dearborn Street, Chicago 10, Illinois, to mail its literature against the Wagner-Murray-Dingell bill to the captain of the negative team.

———ISMA———

State Association Dues. Are the $15 a year dues of the Indiana State Medical Association out of line with what doctors pay in other states? No. A survey by the Oklahoma State Medical Association as of October 1, 1946, reveals that sixteen states pay more, twelve pay less and the 1947 dues of six other states were undecided at that time. Of the forty-one state associations which replied to its questionnaire, the breakdown showed state dues as follows: One $100 (California), two $50, two $35, two $30, four $25, one $22, four $20, seven $15, two $12, four $10, one $8, two $7, three $5 and six undecided. Dues in Ohio are $15. Illinois and Kentucky each pay $10. In Michigan the state dues are $12 a year plus a $25 a year assessment for public relations. Idaho and Oregon have assessments of $10 plus their state dues, while Missouri has a $7 such assessment.

———ISMA———

Year of Achievement. The year 1946 was marked by two outstanding ISMA achievements—organization of Mutual Medical Insurance, Inc., and the Indiana Board for the General Practice of Medicine, Inc. The prepayment medical care company . . . medicine's **objective** opposition to the Wagner-Murray-Dingell bill and all like compulsory sickness insurance plans . . . has met with almost unbelievable success. The profession may well be proud of this company and what it is doing for those in the low income group. The General Practice Board has made rapid strides, too. The year closed with the full quota of Founder Members, and preparations are being made for examinations for those seeking board membership in the future. Indiana medicine has received nation-wide recognition for being the first to establish such a board.



Nine physicians were among 225 upper income patients found guilty of diets wanting in one or more vitamins. Low-vitamin diets are not restricted by income or by intelligence.[2] Greater assurance of adequate vitamin maintenance is available in potent, easy to take, and reasonably priced Upjohn vitamin preparations.

1. New England J. Med. **228**:118 (Jan. 28) 1943.
2. J. A. M. A. **129**:613 (Oct. 27) 1945.

Upjohn
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UPJOHN VITAMINS

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News Notes

Dr. George R. Bloom, who has practiced in Elkhart since his discharge from the Navy in May, has gone into partnership with Dr. S. T. Miller, who has practiced there since 1911.

Dr. J. B. Bennett, who has recently been released from service in the Army Air Force, has established an office in Warren for the practice of medicine.

Formerly with the Indiana State Board of Health as district medical director at Rockville before entering military service, Dr. Phillip T. Hodgin has opened an office at Orleans for the general practice of medicine and surgery. Doctor Hodgin was recently separated from service after more than two years' service, one of which was spent overseas in Fukuoka, Japan.

After being placed on inactive status in July, Dr. Lewis E. Jolly, formerly of Knightstown, is temporarily located in the office of Dr. E. C. Cook, in Madison, where he is engaged in the practice of surgery.

Dr. H. H. Deen, of Leavenworth, has been appointed health officer by Crawford County commissioners. He will fill the vacancy left by Dr. Otis R. Lynch, of Marengo, who has resigned to become medical examiner for the Veterans Administration in Louisville.

Dr. T. J. McKean, of Montpelier, and Mrs. Grace Nordman, of Cairo, Illinois, were married November seventh in the parsonage of the Cairo Baptist Church. Doctor McKean is health commissioner of Montpelier and Blackford County, and since 1939 Mrs. McKean has been city treasurer and city comptroller of Cairo.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The twentieth Annual Meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, Illinois, on February ninth. Registration will commence at 9:00 A.M. and the program will include discussions in the fields of national affairs, economics and medical education. All physicians are invited to attend; there is no registration fee. Cleon A. Nafe, M.D., Indianapolis, is President of the Conference, and Creighton Barker, M.D., New Haven, is the Secretary.

The Bartholomew County Hospital has been given approximately $62,000 for the purpose of establishing x-ray diagnostic and therapeutic facilities and a clinical laboratory. A former Columbus resident, Mr. William H. Donner, now of Philadelphia, first determined what the hospital needed most and what would render most service to the community, and then gave the $62,000 for the laboratory which is already in operation, and the x-ray services which will be available in the near future. Dr. David L. Adler, of Shelbyville, is pathologist.

The American Urological Association offers an annual award for an essay (or essays) on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals. For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

DIRECTORY OF CONVALESCENT HOMES

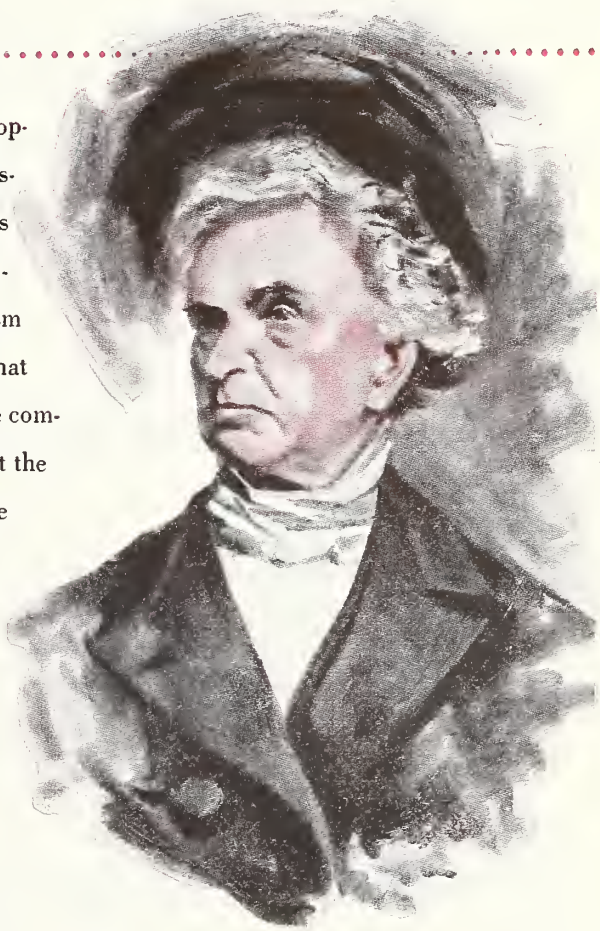
The Committee on Public Health Relations of The New York Academy of Medicine is preparing a new edition of the "Directory of Convalescent Homes in the United States," to be published by the Sturgis Fund of the Winifred Masterson Burke Relief Foundation of White Plains, New York. The last issue of this Directory was published by the Sturgis Fund in 1931 under the auspices of the Committee on Convalescent Care of the American Conference on Hospital Service and has long been out of print. The need of a new directory is recognized by all concerned.

Early in January a questionnaire will be distributed to all recognized convalescent homes maintained by municipalities, counties or voluntary bodies. The information sought deals with the physical plant, the staff, the requirements for admission, the type of patients, therapy, and such other matters as will make the Directory a dependable guide for physicians who wish to refer their patients to institutions for convalescence. The questionnaire is so devised that it can be filled out with a minimum of effort. Convalescent homes that do not receive a questionnaire are urged to request one by writing to E. H. L. Corwin, Executive Secretary, Committee on Public Health Relations, The New York Academy of Medicine, 2 East 103rd Street, New York 29, New York.

Men and Amino Acids

Liebig's researches helped shape the development of chemical science in relation to physiology. He assigned to nitrogenous substances the vital role of tissue building, and demonstrated their importance in the metabolism of other dietary constituents; . . . proved that animal heat and energy are produced by the combustion of food in the body; . . . pointed out the chemical similarity of animal and vegetable tissue; and, in addition, made many basic contributions to agricultural science. Among Liebig's many achievements were the discovery of tyrosine, establishment of the formula of creatine and its decomposition products and of other constituents of tissues and body fluids.

A contemporary paid tribute to Justus von Liebig as "the greatest experimental thinker who has yet appeared among mankind."



JUSTUS VON LIEBIG — 1803-1873

The Arlington Chemical Company

Yonkers 1, Arlington *New York*

First in a Series

American Trudeau Society Postgraduate Course

The Committee on Postgraduate Medical Education of the American Trudeau Society is sponsoring a postgraduate course in thoracic diseases to be held at the University of Wisconsin Medical School, Madison, Wisconsin, March 3-8, 1947. The fee for the course is fifty dollars. Further information regarding this course may be obtained by writing to Cameron St.C. Guild, M.D., Executive Secretary, American Trudeau Society, 1790 Broadway, New York 19, New York.

On November nineteenth a new wing of the Welborn Baptist Hospital, in Evansville, was dedicated in the presence of civic leaders. This new wing was constructed at a cost of $101,455 with an additional cost of $11,000 for furnishings, and provides thirty additional hospital beds, solariums at the end of the corridor of each three floors, and space for the establishment of a hospital library and conference room. Now under construction in the hospital basement is the city's first hospital morgue and amphitheater as well as a pathological clinic.

Deaths

Fred C. Dilly, M.D., of Brazil, died suddenly at his home on November twenty-first, at the age of seventy years. Dr. Dilley was a graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1898. He was a member of the Clay County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Martin Hassenmiller, M.D., of West Baden, died on November eighteenth after an extended illness. He was seventy-seven years of age. Dr. Hassenmiller graduated from the Louisville Medical College in 1901. He was a member of the Orange County Medical Society and the American Medical Association, and an honorary member of the Indiana State Medical Association.

Simeon Lambright, M.D., of Danville, Illinois, died on November ninth at the home of a son in Mishawaka, with whom he was visiting. Dr. Lambright was eighty-three years of age. He was a graduate of the National Normal University, College of Medicine, Lebanon, Ohio, in 1892, and had retired from active medical practice in 1943. Dr. Lambright was a member of the Fountain-Warren County Medical Society, a Fellow of the American Medical Association, and an honorary member of the Indiana State Medical Association.

Lewis F. Mobley, M.D., of Summitville, died on November eighth, following a short illness. He was seventy-one years of age. Dr. Mobley graduated from the Medical College of Indiana, at Indianapolis, in 1902, and for forty years had been a practicing physician in the community of Summitville. In World War I, he served overseas with the rank of major. Doctor Mobley was a member of the Madison County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Earl Palmer, M.D., of Logansport, died recently at the age of sixty-four. He was a graduate of Rush Medical College, in Chicago, in 1906, and had practiced since that time in Logansport, with special attention to psychiatry and neurology. Doctor Palmer was a member of the Cass County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John I. Rinne, Jr., M.D. of Indianapolis, was killed instantly on November ninth in an automobile accident. Doctor Rinne was thirty-four years of age, and was a graduate of the Indiana University School of Medicine in 1936. He practiced three years in Anderson before entering the United States Navy in 1942, and after being released from service in January of this year opened an office in Indianapolis where he practiced until his death.

Otto R. Spigler, M.D., of Terre Haute, died on November twenty-eighth at the age of seventy-one. He was a graduate of the Hospital College of Medicine, in 1902, and had practiced in Terre Haute since that time. Doctor Spigler was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American College of Surgeons, and was a Fellow of the American Medical Association.

E. J. Valentine, M.D., of Shelbyville, died November sixteenth at a Jersey City, New Jersey, hospital, where he was taken when he became ill while visiting relatives in the East. Doctor Valentine was a graduate of the New York Medical College, New York City, in 1933, and had practiced in Shelbyville since 1943. He was forty-five years of age. Doctor Valentine was a member of the Shelby County Medical Society, the Indiana State Medical Association and the American Medical Association.

Sinal drainage"... can be achieved by the introduction of nontoxic, volatile vasoconstrictors, such as ...amphetamine [Benzedrine]."

Russell, H.G.B., abstracted, Proc. Roy. Soc. Med. 36:401.



To relieve the discomfort of sinusitis

The vasoconstrictive vapor of Benzedrine Inhaler, N.N.R., diffuses evenly throughout the upper respiratory tract, opening sinal ostia and ducts which are frequently inaccessible to liquid vasoconstrictors. The sinuses drain. Headache, pressure pain, "stuffiness" and other unpleasant sinusitis symptoms are relieved.

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; menthol, 12.5 mg.; and aromatics.

Smith, Kline & French Laboratories, Philadelphia, Pa.

Benzedrine Inhaler

a better means of nasal medication

Society Reports

Indiana State Medical Association
EXECUTIVE COMMITTEE

October 28, 1946.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; E. M. Shanklin, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Ray E. Smith, executive secretary, and Albert Stump, attorney.

Guests: Members of Committee on Public Policy and Legislation of the Indiana State Medical Association: Norman M. Beatty, M.D., J. William Wright, M.D., co-chairmen; Harold J. Halleck, M.D.; O. T. Scamahorn, M.D.; Robert L. Glass, M.D.

Membership Report

Number of members October 28, 1946	3,450*
Number of members October 28, 1945	3,372
Gain over last year	78

* Includes 849 in military service, 350 World War II veterans, and 155 honorary members.

Treasurer's Office

The treasurer read a report covering anticipated income for 1947, including THE JOURNAL, and was directed to submit the same report to the Council.

Legislative Matters

National

A resolution adopted at the recent national American Legion convention against compulsory health insurance was referred to the House of Delegates by the Executive Committee and the Committee on Public Policy and Legislation jointly, on motion of Dr. Mitchell, seconded by Dr. McCaskey, with the suggestion that the House take commendatory action.

The executive secretary was directed to write a letter congratulating the Owen-Monroe County Medical Society for the fine article against government-controlled medicine which it prepared for publication in The Star-Courier, Bloomington, Indiana, and the article is to be reprinted in THE JOURNAL, on motion of Dr. Mitchell, seconded by Dr. Ferrell.

A letter from the American College of Radiology about the federal cancer control program was referred to the Committee on Control of Cancer, by common consent.

Local

After the annual registration bill is drafted, copies were ordered sent to secretaries of county medical societies for consideration of its contents by the membership.

Dr. Forster announced that a resolution would be presented asking the House of Delegates to approve the activities of the National Board of Medical Examiners and requesting that some means be found whereby the State Board of Medical Registration and Examination could recognize their examination for granting licenses to practice medicine in Indiana.

Statement of receipts and expenditures for September for THE JOURNAL was approved.

Organization Matters

The president reported that representatives of the Indiana State Bar Association, Indiana State Dental Association and the medical association discussed their mutual legislative problems at a dinner October ninth, in accordance with instructions of the 1945 House of Delegates.

The question of dues of physicians remaining in military service was referred to the Council.

Dr. John S. Bobbs was selected as the physician from Indiana to be dramatized on the national A. M.A. radio hook-up, January 25, 1947. The chairman of the Committee on Centennial Celebration is to provide the material for the script.

A letter suggesting that action be taken to procure automobile batteries for physicians was ordered sent to Thomas A. Hendricks at the A.M.A. office. The secretary was directed to notify the author of the letter of this action.

Postwar Medicine

Executive secretary reported on status of veterans' care program, that the Veterans Administration had sent out forms to all members asking if they wish to sign up as participating physicians.

The Journal

Report on Advertising

Additions	$ 343.64
Decreases	51.00
Total increase in advertising in October	$ 292.64
Total increase over budget estimate, 1946	$5,752.81

There being no further business, the meeting was adjourned.

THE JOURNAL wishes for all of its readers a most prosperous and happy New Year!



A good grip on life

With infant mortality at its highest during the first month of life, the fewer the burdens on the baby's endurance, the firmer will be his grip on life. And gastro-intestinal upset, colic and diarrhea can be heavy burdens for an infant.

'Dexin' has proved an excellent "first carbohydrate." Because of its high dextrin content, it (1) resists fermentation by the usual intestinal organisms; (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds.

'Dexin' brand High Dextrin Carbohydrate is simply prepared in hot or cold milk and is readily adaptable to increasing formula needs. 'Dexin' *does* make a difference. 'Dexin' Reg. Trademark

HIGH DEXTRIN CARBOHYDRATE 'Dexin' BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.

Bureau of Publicity

November 4, 1946.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D.; Karl R. Ruddell, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved for release:

Week of December 2, 1946—"Rabbit Fever."
Week of December 9, 1946—"Growing Pains."
Week of December 16, 1946—"Epilepsy."

The executive secretary reported the following activities since the last meeting in regard to publicity on the annual state meeting:

(a) Two special stories written for each Indianapolis daily and photos supplied each paper.

(b) Copies of address before Woman's Auxiliary luncheon sent to Women's editors of all Indianapolis dailies.

(c) Special fifteen-minute broadcast over WISH on October 30.

(d) Representatives of papers and press associations were special guests at annual meeting dinner.

(e) Executive secretary of Indianapolis Medical Society supplied reporters covering meeting with abstracts of lectures.

The chairman read a letter from the Tennessee State Medical Association asking for information on "Hints on Health" columns supplied weekly newspapers.

The executive secretary was directed to gather data on what other state medical organizations are doing in the way of public relations for the information of the bureau.

BUREAU OF PUBLICITY

November 18, 1946.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

News release, warning against overuse of nose drops, for daily and weekly newspapers, was approved.

Public relations programs of the state medical organizations in Michigan and Oklahoma were presented, but consideration of them in detail was postponed until next meeting.

A letter from the councilor of the Fifth District, Ohio State Medical Association, asking about Indiana's radio and press programs, was read.

The secretary announced that records for the new radio series, "Why Do You Worry?", which starts over WFBM, Indianapolis, Monday, December 2, 1946, had been received.

Speakers procured:

November 15, 1946—Cass County Medical Society, Logansport. "Psychiatric Problems Confronting the General Practitioner."

November 15, 1946—Woman's Auxiliary to the St. Joseph County Medical Society, Mishawaka. "Mutual Medical Insurance, Inc."

LOCAL SOCIETY REPORTS

100 PER CENT IN PAYMENT OF 1947 DUES

Carroll County
Sullivan County
Switzerland County

Dearborn-Ohio County Society members held a meeting at the Dillsboro Sanitarium on September twenty-sixth. Dr. D. C. Barrett, director of the Southeastern Branch of the Indiana State Board of Health at Columbus, spoke on "The General Practitioner and the State Board of Health." Eighteen members attended the meeting.

Floyd County Medical Society members met at the New Albany Country Club on November fifteenth. The speaker for this meeting was Dr. P. M. Davis, of New Albany. Twenty-one members and guests were present.

Cass County Medical Society members held a meeting in Logansport on November fifteenth. The nineteen members present heard Dr. Alexander T. Ross, of Indianapolis, speak on "Psychiatric Problems Confronting the General Practitioner."

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, in Clinton, on November twentieth. Dr. William W. Kreible, of Terre Haute, discussed "Diabetic Acidosis." Sixteen members were present.

Porter County Medical Society members held a meeting in Valparaiso, on November twenty-sixth. Dr. Joseph C. Donchess, of Gary, gave an interesting talk, illustrated with lantern slides, on "Supracondylar Fractures of the Elbow."

Boone County Medical Society members met at the Witham Memorial Hospital, in Lebanon, on November fifth. Fifteen members attended the meeting and heard Dr. Lyman T. Meiks, of Indianapolis, discuss "Respiratory Obstructions."

1947 Dues
Are Payable Now!



FLEXIBILITY

Pediatricians recognize the advantages of flexibility in prescribing infant feeding formulas, as the protein, fat, and carbohydrate requirement may vary with the individual baby. Formula preparation with CARTOSE* is simple, rapid, and accurate.

CARTOSE supplies carefully balanced proportions of nonfermentable dextrins in association with maltose and dextrose. Due to the time required for hydrolysis of the higher sugars, absorption is spaced. This lessens the likelihood of distress attributable to the presence of excessive amounts of readily fermentable sugars in the intestinal tract at one time.

When supplementation with vitamins of the B complex is indicated, KINNEY'S YEAST EXTRACT* is suggested for routine incorporation in the daily feeding. The full daily dose is simply added to the twenty-four-hour formula.

KINNEY'S YEAST EXTRACT is prepared from a specially cultured yeast and contains all the known factors of the B complex in natural, palatable form.

CARTOSE and KINNEY'S YEAST EXTRACT are offered for use under the guidance of physicians. They are available only at drugstores.

*The words CARTOSE and KINNEY'S YEAST EXTRACT are registered trademarks of H. W. Kinney & Sons, Inc.

H. W. KINNEY & SONS, INC. (Kinney trademark) COLUMBUS, INDIANA

Patronize Your Advertisers

Delaware-Blackford County Medical Society members held a meeting at the Hotel Roberts, in Muncie, on November nineteenth. A kodachrome motion picture on "Abdominoperineal Proctosigmoidectomy" was presented by Dr. Harry E. Bacon, Professor of Proctology, Temple University School of Medicine, Philadelphia, Pennsylvania; and Dr Mavor J. Moss, of Yorktown, spoke on "International Congress of Brucellosis." Twenty-four members were present.

Montgomery County Medical Society members held a dinner meeting at the Culver Hospital, in Crawfordsville, on October seventeenth. Dr. Everett W. Williams, of Columbus, discussed "Neuropsychiatric Orientation." Twenty-four members and two guests attended the meeting.

Another dinner meeting was held at the Shades Hotel, in Waveland, on November twenty-first. The speakers of the evening were Dr. Walter U. Kennedy, New Castle, president of Mutual Medical Insurance, Inc., and Mr. Guy W. Spring, Indianapolis, executive director, Blue Cross Hospital Service. The meeting was attended by twenty-five members and ten visitors.

TENTH COUNCILOR DISTRICT

Dr. Ernest Dietl of South Bend was elected president of the Thirteenth District Medical Society at the annual meeting held in Elkhart on Wednesday, November 13, 1946. Other officers elected were Dr. Alfred Thompson of Tyner, vice-president, and Dr. O. E. Wilson, of Elkhart, secretary-treasurer.

South Bend was selected for the 1947 meeting place. The date will be Wednesday, November 12.

Speakers at a banquet in the Hotel Elkhart were Dr. Floyd T. Romberger, of Lafayette, president-elect of the Indiana State Medical Association; Dr. Walter U. Kennedy, of New Castle, president of Mutual Medical Insurance, Inc.; Guy Spring, of Indianapolis, executive director of Blue Cross Hospital Service, and Ray E. Smith, of Indianapolis, executive secretary of the state medical association.

In the afternoon the following scientific program was given: "Obesity" by Dr. J. W. Conn, associate professor of Internal Medicine, University of Michigan Medical School; "Office Gynecology" by Dr. Walter J. Reich of the Cook County Post-Graduate School of Medicine, Chicago, and "Diagnosis and Treatment of Intestinal Obstruction" by Dr. Philip Thorek of the American Hospital, Chicago.

Dr. L. A. Elliott and Dr. D. D. Todd, both of Elkhart, held clinical demonstrations on hip fractures and spinal fractures, respectively, at the Elkhart General Hospital, in the morning.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
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A message and greetings from our state president, Mrs. Samuel J. Petronella, arrived a little late for the December JOURNAL, but is quite apropos for January or any month of the year. Quoting from Henry Van Dyke, she writes:

"'I am thinking of you today because it is Christmas, and I wish you happiness; and tomorrow because it is the day after Christmas, I shall still wish you happiness, and so on clear through the year. I may not be able to tell you about it every day because I may be far away, or because both of us may be very busy. But that makes no difference. The thought and wish will be there just the same. In my work and in the business of life, I mean not to be unfair to you or injure you in any way. In my pleasure, if we cannot be together, I would like to share the fun with you. Whatever joy or success comes to you will make me glad. Without pretense, and in plain words, good will to you is what I mean in the Spirit of Christmas.'

"We enter upon the New Year with hope and good cheer, brushing from our eyes every sign of care. May the days so enrich our lives that this year 1947 shall be to us the best of all years.

Mrs. Samuel J. Petronella."

Adams County

Best wishes to Adams County Woman's Auxiliary on their newly-reorganized group.

Mrs. M. L. Habegger, of Berne, was hostess to a group of doctors' wives of Adams County on November thirteenth, for the purpose of reorganizing the Woman's Auxiliary, which had been formed in 1941. Mrs. C. E. Munk, of Kendallville, first vice-president of the State Auxiliary, gave a talk on "Organization," and Mrs. Herman Stucky, daughter of Mrs. Amos Reusser, one of the auxiliary members, gave a musical program.

Delaware-Blackford Counties

A carry-in dinner meeting was held by the Medical Auxiliary at the home of Mrs. J. C. Silvers, in Muncie, on November nineteenth. Plans were made for a Christmas shower, to be held at the Harry Mock School. Members worked on scrapbooks for the school. Later on a library shower will be given for the Mock School.

(Continued on page xlvii)

(Continued from page xliv)

Floyd County

The Floyd County Auxiliary opened its fall activities on October eleventh, with a luncheon at the New Albany Country Club. Miss Primrose Hockey, an exchange English teacher from England, talked on "Rationing in England During the War."

On November eighth Floyd and Clark County Auxiliaries held a guest luncheon meeting at the Country Club. A most instructive talk was given by Dr. Clifford Williams on "Mental Health."

On December thirteenth a luncheon was held at the Country Club, followed by a Christmas program.

The projects for the year are health talks in the schools, legislation and radio talks, and Hygeia subscriptions.

Howard County

Mrs. W. H. Hutto was hostess to the Howard County Auxiliary on November first. Members were urged to subscribe to **Hygeia**, and the auxiliary voted to give a number of subscriptions to several local organizations. The December meeting was the annual banquet, with the Medical Society as host.

Madison County

The Woman's Auxiliary met at the Critchley home Monday evening, on November eighteenth, for the regular monthly dinner meeting. Discussion of a Nurses' Loan Fund highlighted the meeting and plans were made, which when set up, will provide a fund from which girls interested in training for nursing at the St. John's Hickey Memorial Hospital School of Nursing, may receive loans. This is the Madison County project for 1946-1947. Mrs. F. C. Guthrie is president.

Vanderburgh County

The Auxiliary held a luncheon meeting in the Vendome Hotel on November twelfth. Dean Long, Executive Assistant to the President of Evansville College, was the speaker.

Vigo County

The Woman's Auxiliary opened its fall program with a tea at the home of Mrs. J. R. Haslem on October fourteenth. Mrs. Ivan Gilbert and Mrs. Leon Blum reported on the A.M.A. Convention held in San Francisco in July. There was a discussion on "Mutual Medical Insurance."

The auxiliary's project for the year is collecting sample medicines to be sent to Europe and Asia to help relieve the drug shortage in those countries.

On November eighteenth, the auxiliary met at the home of Mrs. William Baldridge, for a covered dish luncheon. Mrs. E. R. Haslem, president, gave a report of the State Medical Convention held in Indianapolis in October.



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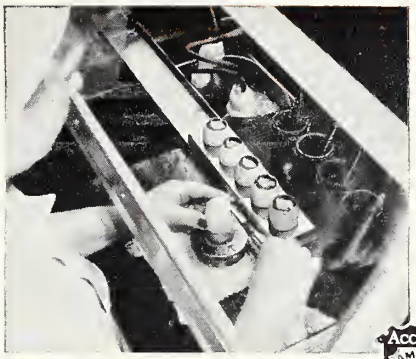
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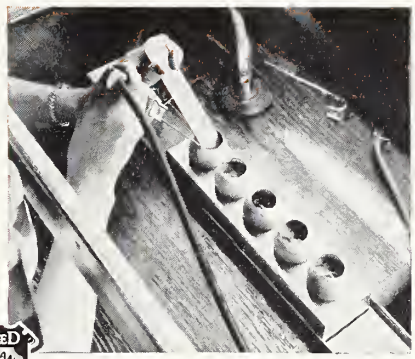
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CURARE IN ANESTHESIA*

RALPH T. KNIGHT, M.D.†

MINNEAPOLIS

SINCE its first application in clinical anesthesia by Dr. Harold Griffith[1] of Montreal in January, 1942, curare has probably come into general use more rapidly than any other drug which has ever entered the field of anesthesiology. It is not the purpose of this paper to rehearse the story of curare in medical knowledge and application. It is a story which is fascinating, covering a greater period of time and being made up of more incidents and adventures than most of us have realized. The whole narrative was told in most interesting detail at the joint Ether Centennial Meeting of the New England and American Societies of Anesthesiologists in Boston in October, 1946, by Dr. Stuart C. Cullen, Professor of Anesthesiology at the University of Iowa. It was he who had immediately followed Griffith in introducing curare by reporting the first large series of anesthesias in which it was used. No one at all interested in this dramatic drug will fail to enjoy this present account by Dr. Cullen, entitled "Curare, Historical Review and Present Experiences," which I presume will appear shortly in the Anesthesiology journal.

In spite of the fact that curare is now familiar to every anesthetist attending this meeting, and to most surgeons, it is probably the most frequently requested subject for programs. Its main action, the blocking of the neuromuscular junction, is well recognized and constantly observed. There is, however, a continuing curiosity as to other possible pharmacological effects and newer variations in the technique of using the drug.

The only available standardized preparation has been intocostrin by Squibb. Originally this was a solution containing 20 milligrams of an extract in each cubic centimeter. With further purification the amount of solids in a comparable solution became less and to avoid a confusion in dosage the terminology was changed to 20 units instead of milligrams per cubic centimeter. More recently the active principle in crystalline form was isolated and the name D-Tubocurarine given to it. This is now available, at least in small quantities, from more than one pharmaceutical house. When this is available in commercial quantities we will probably again speak of doses in milligrams, each milligram representing approximately 6.58 of our present units.

Deep surgical anesthesia has always been required to produce loss of muscle tone. Our general anesthetics produce loss of muscle tone as one of their last effects, requiring a much greater dose than that necessary for unconsciousness and the obliteration of reflex responses. Therefore, to produce relaxation such as needed for present-day extensive abdominal surgery, the brain cells and most other nerve cells must be subjected to a much

PAPER SHORTAGE FORCES JOURNAL TO REDUCE NUMBER OF PAGES

Extra large issues of THE JOURNAL in October (Convention Number) and January (Indiana Medical Year Book Number) depleted our allotment of printing paper and forced us to reduce the number of pages of this issue. We are hopeful that improvement in paper production in the coming months will permit us to keep THE JOURNAL at its normal size.

The Editors.

* Presented before the Section on Anesthesia of the Indiana State Medical Association at the annual meeting, in Indianapolis, October 30, 1946.

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1. Griffith, Harold R., and Johnson, G. E.: Use of Curare in General Anesthesia. **Anesth. 3**:4, 418-421 (July) 1942.

greater dose of anesthetic than desirable. Prostration is too great and recovery delayed.

Spinal anesthesia has been an excellent answer to this problem. With this form of anesthesia only those nerve cells directly concerned with the sensation and muscle tone in a part of the body need be anesthetized, leaving the brain cells unaffected; or, if it is desirable to have the patient unconscious, this can be accomplished with a very small dose of some general anesthetic. With newer techniques in spinal anesthesia concentrations may be reduced to the minimums necessary for the desired effects in the individual patient. Unpublished work by Arrowood and Sarnoff, at Massachusetts General Hospital, and Lund, in Winnipeg, indicate that selective or differential spinal anesthesia of sensory, motor or sympathetic nerve roots may be accomplished by choosing low concentrations of different anesthetics. This is mentioned here as an example of the principles along which the best anesthesia should be developed, and these should be applied to general anesthesia as well.

In general anesthesia it has been more difficult to conserve the effect upon the brain while producing sufficient relaxation. All anesthetics are bad in this respect and some are worse than others. Curare has brought an excellent answer. We are now able to administer selectively only enough general anesthetic to produce unconsciousness, or enough more to block afferent pathways, then in addition or in parallel, enough curare to produce the degree of muscular quietness or relaxation desired. The recovery from curare is very rapid and apparently leaves no undesirable lingering depression or prostration. The recovery from the accompanying small dose of general anesthetic is also rapid and also without undue prostration or depression. This makes our general anesthesia approach closer to the ideal than ever before.

There seem to be two schools of thought in regard to the field of curare. One holds that this drug is a fortunate aid for those cases in which one encounters real difficulty in producing relaxation, but that it should not be used unnecessarily. The other holds that it exhibits less signs of harm than almost any other drug we have had, and that it therefore should be used generously and almost routinely to avoid using any but the lightest doses of our general anesthetics. As time goes on I am more and more inclined to the latter view. This can be carried even so far as to use curare to keep a patient quiet under very light anesthesia for operations not requiring relaxation.

Other effects of curare have been the subject of speculation and experiment. Whitacre[2] and Scott Smith[3] have published small series in which curare was the sole drug used for anesthesia and in which unconsciousness was apparently produced. On the other hand, there have been accounts of subjects who were carried as far as respiratory arrest and claimed they were fully aware of all that transpired. Unconsciousness seems not to be a dependable effect and if it occurs requires extreme dosage. Afferent pathways may be somewhat dampened so that sensation is diminished. I do not know that methods for evaluating this have been devised. These questions seem to me to be quite academic. If these effects are produced to some degree, all well and good, but the drug should be used to produce only the minimum of relaxation needed.

Some have claimed that the drug causes laryngospasm. It is certainly true that under very light anesthesia, such as after a small dose of sodium pentothal, even though 80 or 100 units of intocostrin have been given one may encounter a very wild laryngospasm upon introducing a laryngoscope. I am inclined to believe that this is because of wide-open afferent pathways and failure of the curare to produce relaxation under those circumstances. It is perfectly evident to all that the lighter the anesthesia the greater is the dose of curare required to produce relaxation. In other words the more intense the stimulus coming down the efferent part of the reflex arc the greater the dose of curare needed to stop it at the neuromuscular junction. I doubt that the curare takes any active part in the laryngospasm. In fact, on a great many occasions when laryngospasm has developed during the course of an abdominal operation I have stopped it by giving curare. The pitch of the inspiratory note has become progressively lower on successive inspirations until it has disappeared altogether.

It is probably true however that ordinarily a larger dose is required to block the parasympathetic neuromuscular junctions than the somatic ones, and still, when the abdomen has been relaxed with curare the bowel is apt to be more relaxed than under spinal anesthesia, showing lack of parasympathetic tone.

Speaking of relaxation of the bowel, a queer expression is often used in the operating room which ought to be corrected. Some people speak of the bowel relaxing when it retreats into the abdomen. Of course it is the relaxation of the abdominal and flank muscles which accomplishes this by reduction of intraabdominal pressure. Relaxation of the bowel makes it more apt to protrude.

The effect of curare upon the blood pressure is an interesting topic. Doses large enough to relax the abdominal and intercostal muscles are apt to cause a rise in blood pressure by decreasing the minute-volume of respiratory exchange and thus reducing the clearance of carbon dioxide. This must be corrected by controlled respiration. In an occasional patient such a dose causes moderate vascular relaxation and a consequent moderate lowering of blood pressure. A little ephedrine may

2. Whitacre, Rolland J.: Clinical Observations on the Use of Curare in Anesthesia. **Anesth. 6**:124, 1946.

3. Smith, Scott M.: Curare as an Adjuvant During Inhalation Anesthesia. **Rocky Mountain Med. J.** (May) 1944.

well be used in such a case. Cole[4] showed that massive doses given to dogs caused extreme fall of blood pressure, even though anoxia was prevented, and this was accompanied by hemorrhages from the gastro-intestinal mucosa. The hemorrhages were prevented by giving enough ephedrine with the curare to prevent the blood pressure fall. With continued artificial respiration and ephedrine twenty times the lethal dose of curare was given to dogs without ill effect except the prolonged paralysis from which they recovered.

The greatest practical difficulty in conducting a combined anesthesia with curare is to know what plane of anesthesia has been produced by the general anesthetic. If enough curare has been given to prevent reflex muscular response, how can one even know that the patient is not conscious? On the other hand, if enough curare has been given to produce third plane relaxation, how can one know that he has not also given enough cyclopropane or ether to bring about the same effect alone? I suspect that the latter happens a good many times and the curare is not only wasted but the patient is still subjected to a prostrating dose of the anesthetic. The curare covers up all signs of anesthesia but one. If the dose is never large enough to weaken the diaphragm it will respond reflexly to stimuli which are not stopped by the anesthetic. No other muscle may be able to respond. Holding or irregular movement of the diaphragm will occur if the anesthesia is reduced to the margin between second stage and plane one of third stage. One should make this test at frequent enough intervals to know that he is maintaining only first plane anesthesia but he should remain beyond it to be sure the patient is unconscious.

Pentothal and nitrous oxide together are especially well adapted to be used with curare.[5] With nitrous oxide 65 per cent to 70 per cent one may maintain very light unconsciousness and light analgesia. This is obtained by filling the bag with 2/3 nitrous oxide and 1/3 oxygen, then running each at 500 cc. per minute with enough escape to keep the bag from distending. With this one may give in parallel, from two separate syringes, 10 units of intocostrin with each 25 mg. of sodium pentothal, giving of the two just enough to keep the patient as quiet and relaxed as desired. If one wishes, the curare may be somewhat reduced but I have found the above proportion perfectly satisfactory. The two are best given in parallel in the same proportion from the beginning of induction. Any attempt to vary the two during the operation becomes very confusing but the two together in about the above proportion is a beautiful combination.

As an example of this type of combined anesthesia, I cite the following case: On October 29, 1946, a forty-six-year-old man, weighing approximately 190 pounds, was submitted to a three-quarters mandibulectomy, massive neck dissection and skin graft. The anesthesia was exactly eight hours. During this time he received 2,400 mg. of pentothal, 960 units of curare, nitrous oxide and oxygen each 500 cc. per minute. As supportive treatment on the table he received 1,500 cc. of blood, and 2,000 cc. of 5 per cent dextrose in water. His premedication was morphine sulfate grain 1/4, atropine sulfate grain 1/150. Soon after the induction of anesthesia he received an additional 1/150 grain of atropine intravenously. The blood pressure curve for the first four hours remained at approximately 140/90 with slight variations. For the fifth and sixth hours it ranged around 120/80 and for the last two hours around 110/60. The drop was gradual and the chart appeared quite smooth. The pulse ranged from 110 to 100 for the first two hours, from 90 to 80 during the second two hours and for the remainder of the time was between 70 and 80. Upon conclusion of the surgery, when the patient was lifted from the table, he was moving freely and intercostal respiration was complete. No prostigmine was given at any time. The patient was returned to bed in excellent condition.

Dr. Joe W. Baird, Clinical Associate Professor of Anesthesiology at the University of Minnesota, contrived to put sodium pentothal and intocostrin in one syringe by properly buffering them. He finally found that D-Tubocurarine and sodium pentothal would remain in solution together without buffering. This is a very serviceable mixture.

The combination of nitrous oxide, sodium pentothal and curare are good for any kind of surgery and provides non-inflammable conditions. It has the one fault of sometimes allowing hiccups during upper abdominal surgery. This is undoubtedly because these three drugs do not provide enough blockage of afferent pathways and the diaphragmatic reflex responds to the stimulation. This can be stopped with a little cyclopropane. Possibly it will be found to be satisfactorily controlled by the addition of procaine or some other local anesthetic drug intravenously, thus maintaining the non-inflammable conditions.

Certainly the advent of curare has opened up wonderful possibilities for the improvement of working conditions and increasing the safety and welfare of the patient in general anesthesia.

4. Cole, Frank: A New Lethal Dose of Curare, With Some Observations on the Pathology Produced by Large Doses. **Anesth. 7**:190-197, 1946.

5. Knight, Ralph T.: Combined Use of Pentothal, Intocostrin (Curare) and Nitrous Oxide, **Canad. M.A.J., 55**:4, 356-360 (Oct.) 1946.

OFFICE MANAGEMENT OF DIABETES

R. E. MITCHELL, M.D.

INDIANAPOLIS

MY purpose in presenting this paper is two-fold: First, many of the physicians who are now back from service have not seen a case of diabetes for the past three to five years; these doctors are anxious for refresher courses to help them re-establish their practices. Secondly, my purpose is to impress you with the fact that a large number of these diabetic patients may be seen, examined, and treated in the office. At the present time when our hospitals are so overcrowded and understaffed it is important that we work out some simple method whereby the general practitioner may take care of these diabetics himself.

First, let us classify what types of diabetics can be treated in the office. They must be adults with a mild or moderate type of the disease. A mild type is a diabetic individual requiring no insulin; a moderate diabetic individual is one requiring up to, but not over, forty units of insulin daily. Furthermore, they must be cases without the usual complications, such as acidosis, coma, arteriosclerosis, or gangrene, and must be relatively free from infections or uncontrolled diseases.

Too many physicians regard the treatment of diabetes as surrounded by a halo of mystery. It is a gratifying disease to treat, not only from the standpoint of the patient, but of the doctor as well. And the whole keystone of its control rests in the family physician.

The diagnosis can be made very easily, by a proper history, physical examination, and finding of sugar in the urine. Weight loss in spite of heavy eating, excessive urination with marked thirst, and a persistent marked glycosuria, possibly with signs of acidosis and a fasting blood sugar of more than 120 milligrams, usually confirm the diagnosis. It then becomes the duty and responsibility of the physician to take sufficient time at repeated office visits to impart to his patient the information he needs for the management of his case.

The patient must be informed briefly as to the nature of diabetes, as well as its course, assuring him that his understanding and cooperation will pay large dividends. Advise him to get a handbook of simple, understandable information on diabetes to supplement office discussion. The patient must be impressed, not depressed, with the fact that this is not a disease of days, weeks, or months, but that is considered of lifelong duration, and that plans must be made accordingly. He must be told that following the initial treatment and adjustment of his diabetic condition he personally must be responsible for his day-by-day treatment. He must ever keep in mind that other things being equal, the patient who knows the most about his own disease will probably live the longest and the happiest.

There are four essential steps in calculating a maintainance diet, after determining normal body weight in pounds for the age, height, and sex of the patient, as follows:

1. Convert pounds to kilograms by dividing body weight by 2.2. (See Table I.).

TABLE I

CONVERSION TABLE

2.2 Pounds = 1 Kilogram

BODY WEIGHT		*BODY WEIGHT*		*BODY WEIGHT*	
Pounds	*Kilograms*	*Pounds*	*Kilograms*	*Pounds*	*Kilograms*
15.4	7	83.6	38	151.8	69
17.6	8	85.8	39	154.0	70
19.8	9	88.0	40	156.2	71
22.0	10	90.2	41	158.4	72
24.2	11	92.4	42	160.6	73
26.4	12	94.6	43	162.8	74
28.6	13	96.8	44	165.0	75
30.8	14	99.0	45	167.2	76
33.0	15	101.2	46	169.4	77
35.2	16	103.4	47	171.6	78
37.4	17	105.6	48	173.8	79
39.6	18	107.8	49	176.0	80
41.8	19	110.0	50	178.2	81
44.0	20	112.2	51	180.4	82
46.2	21	114.4	52	182.6	83
48.4	22	116.6	53	184.8	84
50.6	23	118.8	54	187.0	85
52.8	24	121.0	55	189.2	86
55.0	25	123.2	56	191.4	87
57.2	26	125.4	57	193.6	88
59.4	27	127.6	58	195.8	89
61.6	28	129.8	59	198.0	90
63.8	29	132.0	60	200.2	91
66.0	30	134.2	61	202.4	92
68.2	31	136.4	62	204.6	93
70.4	32	138.6	63	206.8	94
72.6	33	140.8	64	209.0	95
74.8	34	143.0	65	211.2	96
77.0	35	145.2	66	213.4	97
79.2	36	147.4	67	215.6	98
81.4	37	149.6	68	217.8	99
				220.0	100

2. Determine caloric allowance per kilogram normal weight.

3. Multiply kilogram of normal weight by caloric allowance per kilogram for total daily caloric allowance.

4. Divide caloric allowance into the proper carbohydrate, protein, and fat content.

For an average male diabetic patient, 30 calories per kilogram normal body weight are allowed; and for an average female diabetic patient, 25 calories per kilogram normal body weight are allowed.

Protein: For a man, one gram per kilogram normal weight is allowed. For a woman, either ¾ or ⅔ of a gram per kilogram is sufficient.

Fat: Usual allowance varies from 75 to 120 grams, depending on patient's underweight or overweight status. A good average is 90 grams.

Carbohydrate: Having determined the protein and fat in the diet, the remainder of the calories are simply prescribed as carbohydrate.

Such a calculation takes about a minute or two for any patient. The procedure is best illustrated by an example, taking the steps in their proper order. Assuming that we were dealing with a patient forty-two years old, sixty-seven inches tall, and a salesman by occupation (See Table II, marked by an asterisk.) the procedure would be as follows:

(1) Normal body weight should be 154 pounds, or 70 kilograms.

(2) Caloric allowance is 30 calories per kilogram (See Table III.). (Patient is doing light work as a salesman.)

(3) Total daily caloric allowance: 70 x 30 = 2,100 calories.

(4) Protein: 1 gram per kilogram = 70 grams.
Fat: 90 grams.

Protein calories: 70 x 4 (cal. per gm.) = 280 calories.

TABLE II

NORMAL WEIGHT IN SEVENTEEN TO THIRTY-FOUR YEAR GROUP

Age	*17-19*		*20-24*		*25-29*		*30-34*	
Height	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
4'10"	109	1	115	4	120	6	123	6
4'11"	111	1	117	4	122	6	125	6
5' 0"	113	1	119	4	124	4	127	6
5' 1"	115	1	121	4	126	6	129	6
5' 2"	118	1	124	4	128	6	131	6
5' 3"	121	1	127	4	131	5	134	6
5' 4"	124	1	131	5	134	5	137	5
5' 5"	128	2	135	6	138	6	141	5
5' 6"	132	2	139	6	142	6	145	5
5' 7"	136	2	142	5	146	6	149	5
5' 8"	140	2	146	5	150	6	154	6
5' 9"	144	3	150	5	154	6	158	6
5'10"	148	3	154	5	158	6	163	8
5'11"	153	3	158	5	163	8	168	10
6' 0"	158	3	163	6	169	10	174	12
6' 1"	163	3	168	6	175	12	180	14

NORMAL WEIGHT IN THIRTY-FIVE TO FIFTY-FOUR YEAR GROUP

Age	*35-39*		*40-44*		*45-49*		*50-54*	
Height	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
4'10"	125	5	128	4	130	3	131	2
4'11"	127	5	130	4	132	3	133	2
5' 0"	129	5	132	4	134	4	135	2
5' 1"	131	5	134	4	136	3	137	2
5' 2"	133	4	136	3	138	2	139	1
5' 3"	136	4	139	3	141	2	142	1
5' 4"	140	4	*142	3	144	2	145	1
5' 5"	144	4	146	3	148	2	149	1
5' 6"	148	4	150	3	152	1	153	1
5' 7"	152	4	154	3	156	1	157	0
5' 8"	157	5	159	4	161	2	162	0
5' 9"	162	6	164	5	166	3	167	1
5'10"	167	8	169	7	171	5	172	2
5'11"	172	10	175	9	177	7	178	4
6' 0"	178	13	181	12	183	10	184	7
6' 1"	184	16	187	15	190	13	191	10

FOR FEMALE WEIGHT, SUBTRACT THE NUMBER OF POUNDS DESIGNATED.

* See reference in text.

TABLE III

DIET PRESCRIPTION

Assuming that we are dealing with a patient who is forty-two years of age, 67 inches tall, and a salesman by occupation, the calculation would be as follows:

(1) Normal body weight would be 154 pounds, or 70 kilograms.
(2) Caloric allowance is 30 calories per kilogram.
(3) Total daily caloric allowance: 70 x 30 = 2,100 calories.
(4) Protein: 1 gram per kilogram = 70 grams.
Fat: = 90 grams.
Protein calories: 70 x 4 = 280 calories.
Fat calories: 90 x 9 = 810 calories.
280 calories (protein) + 810 calories (fat) = 1,090 calories.
Total daily caloric allowance = 2,100 calories.
Calories supplied by protein and fat = 1,090 calories.
Calories to be supplied as carbohydrate = 1,010 calories.
Carbohydrate (grams): 1,010 divided by 4 = 250 grams.
DIET: Carbohydrate, 250 grams; protein, 70 grams; fat, 90 grams.
Based on physical activity, the following allowances are used per kilogram normal body weight:
For a bed patient 25 calories.
For light work 30 calories.
For medium work 35 calories.
For heavy work 40 calories.

Fat calories: 90 x 9 (cal. per gm.) = 810 calories.

280 cal. (protein) plus 810 cal. (fat) = 1,090 calories.

Total daily caloric allowance = 2,100 calories.

Calories supplied by protein and fat = 1,090 calories.

Remaining calories to be supplied as carbohydrate = 1,010 calories.

Carbohydrate (grams): 1,010 divided by 4 = 250 grams.

(Each gram carbohydrate has 4 calories.)

Accordingly, the prescription for his diet is: carbohydrate, 250 grams; protein, 70 grams; and fat, 90 grams.

Having written the prescription for the number of grams of carbohydrate, protein, and fat, it now becomes the physician's duty to select the menu. My practice for years has been to use the *Physicians' Book of Menus for Diabetics*, put out by the Eli Lilly Research Laboratory. From this handbook the doctor's secretary can type out the menu in a few minutes. Instead of having the patient buy a gram scale, which is not only expensive but at the present time difficult to obtain, the food is given by household measurements. In other words, 30 grams of white bread would be equivalent to one slice 3½" x 4" x ½" thick, and 50 grams of cream is approximately four tablespoonfuls. This simplifies the menu, not only for the patient but for the doctor as well. As far as possible the menu should be pleasing and agreeable to the taste of the patient. You can not make a patient eat something he detests. Furthermore, the diet menu should be altered from time to time by substitutions.

One physician in Chicago, whom I know, who treats a large number of diabetics quite successfully, has only three menus of diet that he hands out to his patients; one for the overweight, another for the underweight, and one for the normal individual. These menus are mimeographed and handed out at the office.

In the mild or moderate case of diabetes it is my practice to keep the patient on his menu for at least a week before giving any insulin, and then do a second blood sugar and urinalysis. Having made the urinalysis and fasting blood sugar at the beginning of the week, and repeated it after he has been on his diet for a week, then if I find glycosuria and hyperglycemia it becomes my problem to determine how much insulin this patient will need. Many will not require any insulin if they are sugar-free. Others will require 10 to 30 units of protamine before breakfast. The more severe case will require an additional shot of insulin before supper. By trial and error I then work out the required dose of protamine to keep this patient sugar-free. Blood sugars may be taken weekly until the patient is stabilized, then once a month. If patient is following instructions carefully he may go two to three months or longer between blood sugars. Urinalysis could be done four times daily, before breakfast and three hours after each meal, until the diabetes is well under control —save the specimens and make the tests all at one time.

In my own private practice I now have more than a dozen active diabetics who are coming to my office for treatment. They come at varying intervals of two weeks, one month, two months, or three to four months. With only one or two exceptions, none of these have ever been in the hospital.

The following are four case histories which I wish to present because they are rather typical. Two are women who are overweight; one is a man who is underweight, and one is a man who is only slightly overweight.

CASE REPORTS

Case 1: Mrs. R., aged thirty-eight, weight 185 pounds, was about to have a hysterectomy because of a large fibroid when it was discovered that her blood sugar was 276 mg. The case was first seen in February, 1939. Surgery was postponed five weeks until fasting blood sugar was down to 120 mg. She had an uneventful recovery postoperatively and left the hospital at the usual time with no complications. She was maintained on 30 units of protamine in the morning. Her weight varied from 185 to 203 pounds. Her blood pressure has remained normal. No other complications have occurred. During all these seven years the patient has lead an active, normal life, working in an office as well as maintaining her home and family. She still comes to the office about every two months for a blood sugar check-up. There has been no glycosuria or hyperglycemia of any degree, and only on four occasions has the blood sugar been above normal in seven years. She was then cautioned about her diet and weight.

Case 2: Mr. S., aged sixty-four, was first seen in October, 1944, when he came in for a minor

respiratory infection. He complained of cough and weakness, frequent urination, and loss of ten pounds in weight, from 156 to 146. He was working long, hard hours as a railway mail clerk. Two per cent glycosuria was found; fasting blood sugar was 266 mg. He was put on a diet of 2,250 calories: 70 grams protein, 200 grams carbohydrate, and 130 grams fat, and 25 units of protamine daily. Within a week the blood sugar was down to 90 mg. The patient reports to the office every few weeks. In the seventeen months he has been under office management his blood sugar has not gone above 120. This patient has no complications such as arteriosclerosis. He has never been in the hospital. He was not asked to buy a scale to weigh his food; he has used one of the food charts and has estimated his food.

Case 3: Mrs. P., aged fifty-seven, was referred to my office by an ophthalmologist because of diabetic retinitis. First seen in December, 1944, when her urine showed 4 plus sugar and 4 plus acetone, she complained of dryness of the mouth, frequent urination, and weakness. Blood sugar was 313 mg. (fasting) at the time. Her weight was 195 pounds. She was put on a diet of 1,400 calories: 90 grams protein, 100 gm. carbohydrate, and 70 gm. fat, and was instructed to take 30 units of protamine before breakfast. Ten days later her blood sugar was 96 mg. She has reported at the office every three to six weeks. She has reduced her weight to 180 pounds. The protamine has been increased to 35 units. She makes no complaints; has no symptoms. She has been doing very satisfactorily for fifteen months under office management without any hospitalization.

Case 4: Mr. B., first seen in 1938 with a diagnosis of primary pernicious anemia, with a blood count of 1½ million. Numerous urine examinations were sugar-free. In March, 1940, two years later, his urine showed a faint trace of acetone and 6 per cent sugar. His blood count returned to almost normal following transfusion and liver and iron therapy. In April, 1940, his blood sugar was 268 mg. In three days it was down to 94 mg. He was put on a diet of 2,100 calories: 180 gm. carbohydrate; 75 gm. protein; and 120 gm. fat. He was started on 15 units of protamine. His blood sugar went up three days later to 210 mg., and in less than a week it was down to 60 mg. During the past six years he has come to my office about every six weeks for blood sugar, urinalysis, blood count, physical examination, and advice. The blood sugar has seldom been over 120 mg. He is now on 17 units of protamine. I particularly want to point out that a patient may have two diseases concurrently; in this instance the patient had pernicious anemia and diabetes. He is a retired business man; takes good care of himself; and lives happily on his farm just outside of Indianapolis. He has not been in the hospital since 1938, when he had his blood transfusions.

SUMMARY

A vast majority of the diabetics encountered may be treated in the office without ever having to go to our overcrowded hospitals. Many patients are not willing to submit to hospital treatment, not only because of the expense, but because of the regimentation and bother they loathe to go through. The result is that thousands of diabetics are walking the streets today, many of them knowing that they have diabetes, but reluctant to submit to this strict disciplinary regime because it has not been simplified. Yet common household measurements in diet may be substituted if the disease is not severe.

The patient must be taught enough about his disease to be practically independent. If the physician is willing to devote sufficient time to teach his patient how to figure out his diet, and have complete understanding with him, then there is no disease more gratifying to treat than diabetes.

3419 E. 10TH STREET,
INDIANAPOLIS 1, INDIANA.

CORRECTION

Gross Income Tax Payments to State of Indiana are Deductible from Federal Income Tax

F. Shirley Wilcox, Collector of Internal Revenue, whose article, "Federal Income Tax and the Medical Profession" appeared in the January JOURNAL, received a ruling on December 16, 1946, that Indiana state gross income tax payments are deductible from federal income tax. It is regrettable that the January JOURNAL was being printed at that time, and it was too late to correct his article.

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PRACTICAL CONSIDERATIONS IN THE MANAGEMENT OF THE EPILEPTIC PATIENT*

HOWARD D. FABING, M.D.

CINCINNATI

THE successful management of the epileptic patient is predicated upon accurate history, proper diagnosis, carefully applied anticonvulsant therapy, and good general care. I propose to discuss certain practical suggestions under each of these headings:

History: A careful history is important in providing clues about localization and about choice of therapy. A description of a typical fit is often very revealing. The patient recalls the first attack he ever had, or the most recent one, most clearly. It is well to allow him to describe one attack in his own words. The aura, or warning, if present, should be described in detail. An aura of smell or taste suggests a focus of origin in the uncinate gyrus on the under surface of the temporal lobe. An aura of auditory hallucination suggests temporal lobe origin, whereas an aura of crude flashes of light bespeaks an occipital lobe origin. Hughlings Jackson insisted that all fits were "Jacksonian," in that they all start in one place, but in most cases the spread is so rapid that they appear generalized to the observer. Consequently every effort should be made to find out from the patient or witnesses any evidence of focal onset, because this may reveal focal pathology.

A description of the fit itself by a competent witness usually reveals a story of tonic-clonic movement, but if this is not the case, and if the fit is characterized by evidences of bizarre behavior, the presence of psychomotor epilepsy must be considered. Sometimes these equivalent attacks are interspersed between the usual grand mal tonic-clonic attacks, and witnesses should be questioned specifically about their presence, because this often makes a difference in therapy.

Many medical students and doctors never quite understand the nature of petit mal attacks, and consequently fail to get an adequate history of them. They are of such short duration in many cases, and they are often so minor an event in the patient's life that he will seldom volunteer much information about them. Do not be disarmed about their frequency. I know a girl who has had as many as 125 in a day. In inquiring for their presence it is well to ask if the patient has had any "absences," "dizzy spells," "blank spells," "blackouts," "funny feelings," et cetera. By such leading questions one often hears bizarre word pictures describing petit mal attacks. Since these phenomena do not occur in the ordinary experience of the patient he is often at a loss to find words in his vocabulary to describe them. He may say, "I get a funny clicking sound in my head," or "I am blank for just a second," or, "A funny thought comes into my head and stops my thinking for just a few seconds," or words to that effect. It has been demonstrated with the electro-encephalograph that such short-lived subjective phenomena are usually petit mal attacks, and it is important to note their presence because this makes a great deal of difference in the management of the case.

It is well to get a clear picture of the frequency of attacks, both grand mal and petit mal. Often the patient is at a loss to give an accurate frequency because in an appreciable number of cases seizures do not follow any pattern of frequency. They are hit-or-miss and they often have a tendency to bunch together or to serialize. I often ask the patient to make a mark on the kitchen calendar or jot down in a notebook any attacks which they may have. It is well to note the time of day of the attacks. If they always occur in the early morning or just before meals, the question of hypoglycemia must be entertained.

A careful history will often help in determining the etiology of epileptic attacks. A birth history is important. Eleven per cent of all new-born babies have blood in their spinal fluid; 44 per cent of breech deliveries have blood in their spinal fluid; when forceps are used the incidence of intracranial bleeding is high. It is my feeling that birth trauma is more frequently causative of epileptic seizures than we ordinarily suspect. A history of a head injury, or a history of serious illness, delirium, or a prolonged hyperpyrexia in childhood may divulge the cause of the seizures. Careful family history will often disclose the presence of seizures in blood relatives. It is well to ask the patient to make a careful inquiry into this matter because most of them on first visit will say that there is no family history of seizures. Make note of the alcoholic habits of the patient because one can fail completely in the management of the epileptic if he is a tippler. A diagnosis of epilepsy is often made by history and every effort should be made to make the history a complete one.

Diagnosis: Every epileptic is entitled to a thorough physical examination and to as good a neurological examination as can be given. I feel that every epileptic should have an ophthalmoscopic examination. As for laboratory procedure, I have x-rays of the skull made on every patient although such pictures seldom show anything, but the few cases which have positive findings make the procedure worthwhile as a routine. There is some question about the advisability of lumbar puncture in every case. Although I am inclined to perform

* Presented before the Section on Medicine of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

them, I do not feel it is necessary to do so routinely.

Within the past eight years the science of electro-encephalography has been developed. This instrument of precision, discovered by Hans Berger in 1929, has proved of increasing value in epilepsy. The electro-encephalograph can tell you:

1. Whether the patient has abnormal brain wave patterns or not.
2. Whether the disordered rhythm is generalized or confined to one part of the cortex.
3. Whether the wave pattern is essentially that of grand mal, petit mal, or psychomotor attacks.

Time is not available to elaborate on this laboratory method but it is probably the greatest single diagnostic aid which we have at the present time. It helps us in establishing our diagnosis, in ruling out focal lesions, and in determining the type of fit pattern, and last, is extremely important because drug therapy is predicated upon it.

Pneumo-encephalography cannot be justified as a routine procedure in the diagnostic work-up of the epileptic. This usually should be confined to cases where the suspicion of a focal lesion is strong, or to cases of epilepsy following a well-established head injury. A glucose tolerance test should be performed in all cases where attacks seem to occur when the patient is hungry, in the early morning, or just before mealtime. I strongly urge that such glucose tolerance tests be continued for five hours rather than the usual three hours. Finally, every epileptic should have his carotid sinuses investigated. This is a quick procedure which can be done during the physical examination by massaging the bifurcation of the common carotid artery against the transverse processes of the cervical vertebrae vigorously for ten seconds on each side of the neck.

In summary, the diagnostic work-up of the epileptic should include as a routine:

1. Physical examination with carotid sinus stimulation.
2. Neurological examination with ophthalmological examination.
3. Electro-encephalography, if available.
4. X-ray study of the skull.

Elective procedures include:

1. Lumbar puncture.
2. Glucose tolerance test.
3. Pneumo-encephalogram.

Anticonvulsant Therapy: After determining that epileptic seizures are not due to focal brain disease requiring neurosurgical intervention we turn to the use of anticonvulsant drugs. The oldest drug used in this disorder is sodium bromide. I have not prescribed one dose of this medicine since I have been in practice. I feel that it is dangerous because its action is cumulative, it dulls the intellect, and has no anticonvulsant effect. Phenobarbital was the next drug used. It has some anticonvulsant effect and undoubtedly has controlled many an epileptic. It is of no value whatever in petit mal seizures and it makes psychomotor attacks worse. It is a soporific, as we all know, and it dulls the intellect of the patient. Much of what we have called deterioration of epilepsy is often chronic barbiturate poisoning.

The discovery of sodium diphenyl hydantoinate or dilantin by Merritt and Putnam ushered in a new era in the treatment of epilepsy. It is the most effective medication in use in the control of grand mal or psychomotor seizures. Many of the failures with dilantin are failures to use the drug properly. When given to an adult in doses of less than four and one-half grains a day it is of no use whatever. I cannot stress this too much because I see patients repeatedly who have been given one and one-half to three grains of the drug daily and have gotten no results whatever from it. I ask that you look on dilantin as you do on the sulfa drugs. It is of no value to give a patient five grains of sulfanilamide or sulfathiazole a day. If you are going to get anywhere with the drug you must push it up to a proper blood level and to therapeutically active concentrations. The same is true of dilantin, and the minimal dose, to repeat, is four and one-half grains in an adult. It is not possible to follow Young's Rule in children but it is necessary to push up the dose to an effective level. With very young children who cannot swallow capsules it is best to dissolve the contents of the capsule in a small quantity of cream.

The difficulty with dilantin is that the effective dose is very often near the toxic dose. I have seen patients who show no effects of toxicity on four and one-half grains daily but who have all the toxic manifestations on six grains daily. A simple guide to the presence of toxicity in dilantin is the presence of nystagmus. When active nystagmus is present the patient is getting too much of the drug and soon will develop diplopia and ataxia of the trunk and extremities. Drug rash also develops in a small percentage of patients on dilantin therapy. If the rash is mild it is often possible to continue the drug and the rash will disappear. When it is florid the drug cannot be used. One of the most troublesome long-range effects of dilantin is hypertrophy of the gums. To avoid this it is necessary for the patient to observe scrupulous mouth hygiene. This includes careful and frequent brushing of the teeth, rinsing the mouth after each meal, and massaging the gums each day. Despite this, gum hypertrophy occasionally becomes severe.

The next drug is tridione. It is a new preparation which has proved to be much more effective in the control of petit mal seizures than any other compound. Unfortunately recent reports show that the drug produces agranulocytosis on occasion, and therefore, if it is to be used, a weekly check on the white blood count must be made for the first two months of its use. Often when dilantin cannot be used in doses large enough to control the seizures without developing toxic ataxias a combination of dilantin and phenobarbital can be used. Recent reports show that occasionally combinations of dilantin and tridione will be effective in resistant

cases. New anticonvulsant drugs of the hydantoin group will soon be available. One of them is hydantal or, as it has now come to be known, mesantoin. Dr. Jerry Price, of the Neurological Institute of New York, has recently written me his summary on the use of this drug in 109 cases. It is as follows:

"1. Shorter duration periods of seizures are more favorable than long ones. Present age and age of onset apparently has no unusual influence.

"2. Comparison of mesantoin and dilantin in 53 cases was as follows: mesantoin superior to dilantin in 22 cases, equal in 10, and inferior in 21 cases. Reduction of seizures is probably in favor of dilantin in an unselected group—the 109 cases mentioned are those wholly resistant or refractory to other forms of treatment. The difference in toxicity of the two drugs is essentially the fundamental value of mesantoin. Undoubtedly mesantoin is helpful in a selected group even to the point of keeping them seizure-free after toxic doses of dilantin have failed to control the seizures.

"3. Hypertrophic gingivitis, associated with dilantin or phenobarbital, is completely relieved by mesantoin. Massage and surgical means of treatment are superfluous.

"4. Grand mal, psychomotor and petit mal seizures are reduced in number by mesantoin essentially in this order.

"5. Care should be exercised in changing from dilantin to mesantoin, and in the reverse order, as well. Sudden changes have been associated with personality disturbances or the occurrence of psychomotor attacks for the first time as judged by the history of previous attacks."

My associate, Dr. J. Robert Hawkins, and I, as well as Dr. R. Finley Gayle, of Richmond, Virginia, have made clinical trials with another drug of this series—sodium diphenylene diimide. Although much larger doses are needed to control seizures, it does not cause gum hypertrophy nor does it cause the toxic side-reactions of dilantin. It is hoped that this drug may be made available in the near future. I feel confident that within the next few years there will be many compounds of this general group which will be available for medical use.

In summary, dilantin is the drug of choice, except in isolated petit mal attacks, where tridione is the most effective. Dilantin in small doses may just as well be poured down the sink because it is completely ineffective. The effective dose is near the toxic dose and a great deal of clinical ingenuity is needed to arrive at the proper level. Dilantin plus phenobarbital, and dilantin plus tridione are sometimes effective where dilantin alone fails.

General Care: It is imperative that the clinician make a good appraisal of the intelligence of the epileptic patient with whom he is dealing. The mentally deficient epileptic is troublesome, unpredictable, and incapable of maintaining himself on a therapeutic program. Therefore it is necessary in such cases to put the entire burden in the hands of a more intelligent relative. On the other hand, the highly intelligent, sensitive epileptic is assailed with fears and doubts about himself and his condition. It is necessary to guide the intelligent epileptic through his uncertainties. The wisest course is to arm him with a copy of the book "Science and Seizures," by Dr. William G. Lennox, Boston, Massachusetts. This book is published by Harper & Company and should be in the hands of every intelligent epileptic, because it will answer many of the questions which arise in his mind. Another intelligent move is to get the epileptic to enroll in the American Epilepsy League, Incorporated, 50 State Street, Boston 9, Massachusetts. The purpose of this organization is to stimulate interest in research and to distribute information on epilepsy written in the light of present-day knowledge and conditions. It is backed by most of the country's outstanding epileptologists, and I assure you that its aims are the highest. Material distributed periodically by the League is well chosen and keeps the epileptic well informed of present day investigation in non-technical terms.

A question in the general management of the epileptic is often the one of driving a car. This is prohibited by law in some states. It is my impression that if a known epileptic has been relieved of his seizures for a period of a year or more, is a responsible citizen, is not likely to quit his therapeutic program, and if he does not indulge in excesses of alcohol, he should be permitted to drive. Another question which commonly confronts the epileptic is that of marriage. Dr. Lennox has stated that marriage with or without children is not necessarily precluded by the presence of seizures. He points out that the hereditary factor in epilepsy is about the same as that in diabetes, and about one-eighth that in migraine. The chance that a child of the average epileptic will be epileptic is about one in forty. Abnormal electro-encephalographic patterns are inherited. It is wise to have an epileptic who contemplates marriage to have an electro-encephalogram performed on himself, as well as on the chosen mate. If they both have abnormal EEG's the possibility of epileptic children will be higher than one to forty, as stated above, and should give some pause.

The next and final fact in the general care of the epileptic is activity. Every effort should be made to make this patient a part of the social world in which he lives. The more wholesome the intellectual and physical activity, the better. It has been demonstrated that the epileptic is more likely to have seizures in a completely sedentary environment than when mentally and physically occupied. On the other hand, excessive fatigue and excessive emotional stress undoubtedly predispose the patient to seizures. The best advice is to inculcate into the epileptic that happy mean which has been the ideal of all sensible living down the ages.

THE JOURNAL

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

One Big Day

January 12, 1947, will go down in our book as one of the busiest days in the long history of the Indiana State Medical Association, two of its most important groups holding their mid-winter sessions at that time. The Council met at 9:00 A.M., with a surprisingly large turnout for the opening hour. Other members, delayed in arriving, reported early in the session.

A rather long agenda was "tackled" and carried through right on time, though some of the discussions seemed a bit too long. Councilor reports were few, this being an indication that all is well in the various districts. Dr. W. H. Howard, of the Tenth District, not being able to be present, had mailed in a report of affairs in his bailiwick.

Dr. Cy Clark made a detailed report of the nursing situation and plans were discussed as to how this shortage might be alleviated, yet not interfere with the graduate nurse setup. The editor, on request of the Council, outlined what he believed to be the duties of the members of the Editorial Board, a matter that for some time has had some discussion. The outline presented seemed satisfactory to Council members.

Dr. W. U. Kennedy made a report of the state of affairs in the Mutual Medical Insurance program, it being apparent from this report that matters are progressing nicely. Medical care of veterans was discussed by Dr. C. F. Thompson, the report indicating that the committee is quite busy getting things under way.

A general consideration of the plans for the French Lick meeting in October was then had, Ray Smith reporting that he and Miss Kribs met with the arrangements chairmen, Drs. Boyd and Hauss, together with the hotel management, and

that final plans are being consummated. A change in plans of session was discussed, many Council members favoring a full three-day session; however, final disposition of this matter was deferred until the April meeting.

Plans were also suggested for the holding of the final meeting of the House of Delegates on Thursday noon. Three thousand dollars was the appropriation for the expenses of the session.

Dr. L. E. Burney presented a report of the legislative program of the State Board of Health, and Dr. Norman Beatty gave a pre-session résumé of what may be expected from the current session of the Indiana General Assembly. Albert Stump briefly discussed the annual registration bill, about to be introduced.

Nominations of two members of the Editorial Board was deferred until the April meeting. Sunday, April 13, was set as the date for the next meeting of the Council.

Doctor Nafe, having been elected as president-elect for this year, had sent in his resignation as Chairman of the Executive Committee, which post he had held for ten years. Dr. Carl McCaskey was elected to this position, and Dr. Walter Portteus was named as the second member. Dr. Alfred Ellison, of South Bend, long-time Council member, was named as Chairman of the Council for 1947.

An annual appropriation of $3,000 was voted as a scholarship fund, to be used in defraying part of the expenses of some half dozen worthy medical students. Details of this program are to be worked out and will be reported fully at a later time.

At 1:30 P.M. the Secretaries Conference convened, with a good attendance. Doctor Nafe made the address of welcome, following which Doctor Hamer reported on the House of Delegates of the A.M.A., at their recent Chicago session. Drs. Burney and Wright reported on legislative matters, while Doctor Thompson made an exhaustive report on just what the Veterans Administration is doing and how it operates.

Dr. J. S. De Tar, Chairman of the public Relations Committee of the Michigan State Medical Association, was the guest speaker for the afternoon session. His talk, of an informal character, was received with much interest, it being generally recognized that Michigan is well out in front in this important matter. Doctor Kennedy made a detailed report on Mutual Medical Insurance, Inc., and Doctor Shanklin reported on matters concerning THE JOURNAL.

Mrs. S. J. Petronella, of East Chicago, president of the Woman's Auxiliary to the Indiana State Medical Association, made a brief address, commenting on the work of that group and offering suggestions as to how the State Association might further the work of her organization.

Miss Nancy Scramlin, of Muncie, president of the Indiana Nurses Association, presented some observations on the shortage of nurses, while Dr. H. N. Smith, of Brookville, talked on rural medical care.

Many of the papers presented during this session will be printed in later numbers of our magazine.

The dinner session, held in the Riley Room, was well attended, and both of the guest speakers were well received. President Romberger talked about our county medical societies, and Dr. George F. Lull, Secretary and General Manager of the American Medical Association, chose as his subject, "American Medicine Looks to the Future."

Thus ended a busy day, many of those in attendance having a twelve-hour sitting, from nine until nine, a bit too much for the average physician, but they seemed to enjoy it.

A Double Loss to Indiana Medicine

Two Central Indiana men recently died, their passing meaning a very great loss to the medical profession. One, Dr. William T. Lawson, of Danville, long known as the "Patriarch of Hoosier Medicine"; the other Mr. William H. Coleman, of Indianapolis.

Dr. Lawson, of whom we have written many times in the past few years, had attained the age of ninety-seven, and until very recently had attended to his professional duties, not forgetting to make the annual trip to our state association conventions. For many years he had served as secretary of his local society, his records being always complete and his remittances to headquarters being "right on the dot."

He was graduated from Miami Medical College in 1878, making his years of active service sixty-seven. Few men will be more sorely missed at our annual meetings; Dr. Lawson had the faculty of remembering folks and on greeting him he would say, "How are things up in (whatever town one came from)?" He was an interesting talker and, unlike so many of the oldsters, he liked to talk about present-day matters, though if pressed, could do a bit of most interesting reminiscence.

One favorite topic was his first state meeting, "held in a little church on the Circle." He mentioned many names of those in attendance at this gathering, names we recall from our early days in the profession.

Few men of our profession had so firmly established themselves in their home community as had Dr. Lawson; he was beloved by all who knew him, and few men in our profession will be missed as much by his fellow citizens.

Mr. Coleman, best known to the medical profession as the donor of Coleman Hospital at our medical center, was an Indianapolis business man of high standing. In later years he was better known for his philanthropic acts, including the building of the hospital bearing the family name and a memorial to a daughter.

The obituary notices in the Indianapolis press bore out the fact that he was a leading citizen of that community, commanding the respect of every one with whom he came in contact.

His name, the family name, will remain as an

imperishable thing, his monument perpetually reminding us, as well as other citizens, of a truly great man.

Taxes

Most everyone, including physicians, is deeply interested when tax subjects are under discussion; taxes are always present, in these days. The General Assembly, now in session, will devote much of its time to tax problems, since it seems certain that additional tax monies will have to be raised during the coming years. Practically every city within our state has its own tax problems, its annual expenditures having been upped in no small degree. Already these civic communities have been making "sheep's eyes" at the somewhat large general fund balance now owned by the state, as well as being more than commonly interested in a larger "cut" from our gasoline tax.

To one who has made even a casual study of city management these past few years there is no surprise about the plight in which some of them find themselves. There has been an era of creating new jobs and of adding additional employees in this or that department, often these being not so necessary. We might add that the same rule applies to "government jobs," many of the bureaus and alphabetical outfits being grossly overmanned, yet new employees constantly are being added.

A recent official report indicates that several million federal employees soon will find themselves detached from jobs that have been of the sinecure sort and we trust that that day soon may dawn—we should like to see wholesale changes in many federal agencies.

In city affairs, however, there are some departments that need more money, they need additional men to properly man their departments. We specifically refer to the police and fire departments of our larger cities. Members have been underpaid for a long time, and now that the cost of living has advanced to such a high rate there is more and greater need for additional pay. We might also include the teaching profession; if there is one group which for years has been underpaid it is our teachers. In most of our cities investigation will reveal that the building janitors commonly are paid as much—in many instances more —than our teachers, even though the latter have a substantial financial investment at stake—the cost of their own education. We seriously doubt if any of our citizens would object to a higher rate of pay for these cases.

This tax problem is becoming more and more complex as the days go by; the mere "keeping track" of when taxes of various sorts come due is no little chore. One man, the head of a rather small manufacturing outfit, recently told us that it cost his firm $7,000 per year for clerical help to look after tax matters alone.

Our local Chamber of Commerce annually sends to its membership a tax calendar upon which is set out, month by month and day by day, just what taxes and tax reports are due and where to send these reports and these remittances. This is a very interesting four-page document; it tells the tax story in a brief way, yet is such that it makes one sit back and think.

We recall, back in our Wild Cat days, when the taxpayer had such things on his mind but two times in any one year, when the spring and fall taxes were due. Most folk of those days did not have a bank account—they went to Delphi and paid their taxes, in person and in cash. This was preceded by hauling some grain to market, selling a few extra chickens and turkeys, perhaps a few pounds of butter and a few dozens of eggs. With this chore completed the taxpayer had a respite for some six months, save for the one day each year when he was obligated to work on the "township roads." But as of today few of us have a single week when we are not reminded that a tax report—perhaps with a check—is coming up.

Let's study the Hammond Chamber of Commerce bulletin a bit. The first item is city taxes—exactly eighteen items in this list, and this a moderate-sized city. In addition to this list of taxes, all of which come due in January, the same month lists twenty-six state and federal taxes of various sorts. February, our shortest month, shows but six tax items to be considered, while March comes along with fifteen, April seven, May five. June, however, shows a step-up, there being ten licenses and taxes to be looked after. July accounts for twelve, with none listed for August—probably because this is the popular vacation month and folk just don't want to be bothered about taxes and license fees when on vacation. September has five, October six, November one, December four.

We are also reminded that there are exactly eleven items that must be reported on every month. So there we have the complete tax picture as it now applies to an average Indiana community; it means a lot of detail bookkeeping and it means a lot of money, this thing of trying to keep up with the legislative chaps who continually are seeking new tax sources.

We believe our folk should have a more personal interest in what becomes of our tax monies; are all these taxes necessary and is the money received therefrom properly spent; are there not means by which the amount of official and clerical help now employed could be cut down to a large degree? We believe the answer is "yes," and the sooner we begin to demand a response to that answer, just that much sooner will our tax bills be reduced—not that we expect to get back to the eighties or nineties, but we would like to get back to the days when one earned a dollar he would be able to call a major part thereof his very own.

Bigelow's Original Announcement

The following editorial, which is reprinted from the November 21 issue of **The New England Journal of Medicine**, with their permission, is a valuable addition to our history of anesthesia, a subject in which many of our men are interested:

On November 18, 1846, the Boston Medical and Surgical Journal had the privilege of publishing the first detailed public announcement to the medical profession of Morton's demonstration of surgical anesthesia at the Massachusetts General Hospital on October 16 of the same year. The paper was written by Henry Jacob Bigelow, a Boston surgeon of twenty-eight, who had witnessed the first operation and the second, on October 17, and had forced the issue to disclose the nature of the new agent at the time of a third operation on November 9. In the meantime Bigelow made a brief statement on the subject at a meeting of the American Academy of Arts and Sciences on November 3. Moreover, the published paper was presumably essentially the same paper as that communicated by Bigelow to the members of the Boston Society of Medical Improvement on November 9, the day on which the third demonstration at the Massachusetts General Hospital took place. This operation, a formidable amputation, must have fully convinced young Bigelow of the simplicity and safety of ether insensibility, even if he was in any way doubtful of its value prior to November 9.

Bigelow's paper is probably the most important medical announcement ever to be so issued and thus brought to the attention of the medical profession, as is pointed out in a paper published elsewhere in this issue of the Journal. Although news of the first demonstration had been published in both the Boston Daily Journal and the Daily Evening Transcript on the next day, October 17, and Bigelow had talked about this and subsequent operations to local societies, the news did not have the ring of complete authenticity until it was printed in a well recognized, although small, accredited medical journal. The standing of the surgeon, John Collins Warren, was of international renown. So was the reputation of young Bigelow's father, Jacob. If the latter's oldest son, Henry Jacob, was not so well known outside Boston, at least his name was accepted, and the clear account, skillfully worded, was a document of prime importance, which was readily snatched up by eager hands in both America and abroad. Morton was indeed fortunate in his official announcer for in a few months "anesthesia," a name given to the state of insensibility produced by ether by Oliver Wendell Holmes in a letter to Morton dated November 21, 1846, became a world-wide procedure. That the first practical application of the method was an epoch-making event was fully recognized by the editor of the Journal, Dr. J. V. C. Smith, for there appeared in the same number as Bigelow's paper the following editorial calling attention to the article and its significance.

> Operations without Pain. — In the leading article of this day's Journal, by Dr. H. J. Bigelow, the profession will notice that an impression exists here in Boston that a remarkable discovery has been made. Unlike the farce and trickery of mesmerism this is based on scientific principles, and is solely in the hands of gentlemen of high professional attainments, who make no secret of the matter or manner. To prevent it from being abused and falling into the power of low, evil-minded, irresponsible persons, we are informed that the discoverer has secured a patent, and that means were taken to have the same security in Europe even before publicity was given to it here. Without further remarks, we cheerfully publish all that has been given us on the subject, and wait with impatience for the decision of the profession in regard to its real value.

Bigelow's communication was reprinted the next day in the Boston Daily Advertiser, Bigelow had the paper reprinted himself, and the Hartford Courant printed it as a supplement to the issue of December 26, 1846. The reprint in the Advertiser was sent, with a letter, by Jacob Bigelow to Francis Boott, of London, who arranged for publication in the Lancet on January 2, 1847. Robert Liston, aware of Jacob Bigelow's letter, operated on December 21, 1846, "with the most perfect and satisfactory results." The "new gas" had been accepted by competent surgeons, both in this country and abroad, in a few months, so that the editor's "impatience" was not of long duration. Medicine's greatest single gift to suffering humanity thus was distributed rapidly and efficiently, even taking into account the rate of communication in vogue in 1846. Bigelow's paper was the announcement that gave authenticity and substance to the gift.

Army Medical Officers Wanted

Some 5,000 of the younger medical officers of the late war have received letters from Surgeon General Norman T. Kirk regarding enlistment as such in the Regular Army. Several hundred such officers are needed, according to the present program. While a number of the younger medical officers already have decided to make the Army their career there are not enough enlistments to fill the quota.

These young men, most of whom will be commissioned as first lieutenants, will be paid $3,372 per year, if they have no dependents; if there are dependents this will be upped to $3,804. Promotions in rank will of course call for a higher rate of pay. One of the strongest inducements, it seems, is the pledge of General Kirk that "medical officers will be relieved to the maximum extent of tactical and administrative assignments, for purely professional work."

This suggestion will do away with the most common objections raised by medical officers in the recent war activities, that their time was too much occupied in "paper work" and too little opportunity afforded for professional duties.

Another strong feature of the Surgeon General's program is that all these enlisted men will be given every advantage for study; he proposes to make it possible for almost all of them to seek certification by the various Boards, while those desiring to take up a specialty will be given full opportunity to do so.

Again, the "three-year men," those who attended the continuous session schools—as most of them did—will have no trouble in meeting the Army Medical Corps requirements of a full four-year course, plus an internship in an intern-approved hospital. This four-year requirement has been waived. However, no one will be accepted for a

commission who is not a graduate of an "approved" medical school.

All such officers will be urged to take advantage of the special training programs offered, looking toward a Board certification at a later period.

Complete, modern laboratory facilities will be available to all the men in this group, thus facilitating such studies as they may wish to pursue.

It would seem that all this affords an opportunity to those of our younger men who have had a taste of Army life and like it. Any of our members interested will do well to contact General Kirk at once.

Editorial Notes

The selection of Dr. Alfred Ellison, of South Bend, as Council Chairman, is a merited honor, one unusually well earned. For many years he has been a member of that body, and few men are more familiar with Council affairs than he. His advice on matters in general have been solicited by those who know him best; in fact, he is generally called "Judge" Ellison by his intimates. We believe his term in this office will be of material benefit to the Association.

Membership records for 1946 indicate a gain of 120 over the previous year, making the total 3,500. There is no good reason why this figure should not near the 4,000 mark in 1947. There are many men in active practice who should be on our rolls and a little more activity among the component societies will bring this about. However, we by no means favor "letting down the bars" just to increase our membership; our present high standards must be maintained. But here and there over the State are many men who, for one reason or another, have not "joined up" and it is these men we would like to see on our lists. A little salesmanship will bring many of them in.

"Cy" Rutherford directs our attention to an error we committed recently. In a note re the election of Dr. Carl McCaskey as president-elect of the American Academy of Ophthalmology and Oto-Laryngology we stated that this was the first time the honor had come to Indiana. We are reminded that a long time ago Dr. John J. Kyle, of Indianapolis, served as head of that organization, and some time later the late Dr. John F. Barnhill also was accorded that honor. Dr. Barnhill, at the time of his election, was a resident of Florida, but just the same we all claim "Uncle Jeff" as a native Hoosier.

The City Council of Goshen has voted in favor of a municipal hospital and authorized a commission of twelve to take the necessary steps to get things going. Two local physicians have been named as members of this commission.

Our state hospitals continue to be overcrowded, with not many prospects of immediate relief, chiefly due to the building material complex. In passing, we cannot refrain from mentioning that in our home community there recently have been constructed no less than seven new "taverns," of the night club variety, while several hundred returned service men are vainly trying to get material to build themselves a home! But, to return to the hospital matter, Governor Gates recently made a request that Indiana be permitted to use Wakeman Hospital, at Camp Atterbury, for some of our mental patients. This would materially alleviate a most critical situation.

The Michigan State Medical Society announces a Clinical Conference, in Detroit, March 11-14. This postgraduate study will be under the direction of the University of Michigan and Wayne University, with the cooperation of the Wayne County Medical Society and the Michigan Foundation for Medical and Health Education. Tuesday, March 11, will be given over to surgical clinics in Detroit hospitals, and demonstrations and lectures for the ensuing three days, these to be given at the Book-Cadillac Hotel. Programs for the event will be ready for mailing early in February. Members of State Medical Associations of neighboring states are invited to attend this clinic. Further information may be had by addressing Grover C. Penberthy, 2020 Olds Tower, Lansing 8, Michigan.

A group of three persons, a man and two women, arrested in Northern Indiana on a charge of illegal practice of medicine recently was on trial in the local court. Mention was made of these arrests in a recent number of THE JOURNAL. They had been charged with selling a "Virillum Tube," whatever that may be. The male member of the trio testified that while he was not a physician he frequently was addressed as "Doctor"; stated that he had had a limited education, completing the sixth grade in school and that, after marrying a woman who formerly worked in the office of a medical man, had "taken a course" in a Chicago cult "school." His wife told her story as to her experiences in a doctor's office, while the third member of the trio disclaimed any connection with the sales of the device. This is but another example of "a little knowledge"; we have known of dozens of such instances. Yet, this same ilk want separate licensing boards! This "health tube," by the way, sold for the tidy sum of $300, and was to be worn attached to the clothing of the sucker.

An interesting bit of data was recently observed in one of the numerous publications coming to our attention. This contained the statement that the infant death rate from measles, scarlet fever, whooping cough and diphtheria is only about one-twentieth of what it was thirty years ago. The present death rate from these diseases is 7.2 per one hundred thousand. The figures are taken from a study of statistics from 1911-15 to 1941-45 and have been compiled by the Metropolitan Life Insurance Company.

A news note indicates that a downstate school had been closed, temporarily, because of a "diphtheria epidemic," seven children in one family having been infected with the disease, altogether thirteen cases having been reported in that community, with one death. We cannot understand this; in enlightened Indiana we still have diphtheria, a disease that definitely is preventable. This should prove another argument in favor of full-time county health officers. It should be the job of someone to see that such things just don't happen.

The aftermath and the repercussions from the recent election continue to be of interest to most every citizen. The "ins" have not yet recovered sufficiently from the shock to say anything definite about it, and the victors have not yet recovered from their surprise at the extent of their victory. We were quite interested in an editorial in a recent number of the North Carolina State Medical Journal, in which Editor Wingate Johnson gives a very frank analysis of the matter. Coming from a "Deep South" editor, we were somewhat surprised at his frankness. He feels that the vote was a distinct slap at the New Deal and at the present administration. The true answer, whatever it may be, probably will come along in the next two years, but the fact remains that we have a new governmental setup, one that at least could be less of a menace to our profession.

Having had time to look over the "Indiana Medical Year Book," which we hope to publish in January of each year from now on, we would be pleased to have any suggestions for future numbers. This issue, while it was planned several months ahead of publication date, contains all items we have in mind, save the one on Federal Inheritance Taxes. If there is any item you would like to have included in the 1948 volume, please send the suggestion in to headquarters, where it will receive the attention of the editorial group. The cost of this issue was considerably higher than normal, but this was more than offset by a happy thought of Ray Smith, the managing editor. He circularized many business institutions, solicitng ads for this special number, and succeeded in gaining more than enough advertising to pay the additional costs. We suggest that this number be kept right on your desk—you will find it mighty handy, lots of times.

News reports are to the effect that Clay County Hospital has received a bequest in considerable sum from the late John T. McRoy, a former resident of Brazil. It is planned to use this money for the erection of a nurses home. Since the nurses presently are quartered in the hospital proper, many new beds therein will be available at a later date.

Traffic accidents, showing a letdown during the gas restrictions, are now on the way up, according to figures recently released by the National Safety Council, the increase being of such degree as to cause many of our traffic police departments to seriously consider the way out. We are quite inclined to agree with Chief Killian, of the Indiana State Highway police, in his statement that sterner methods for the control of "drunken driving" must be instituted. Frankly, we see no reason why all such offenders should not receive the "limit," rather than having a small fine, with suspended sentence, handed out. Ever since the day of the invention of the automobile too many drivers have tried mixing alcohol with their gasoline; it never has worked, never will work, and the sooner our enforcing agencies begin a relentless war on all of the offenders, the better it will be for all concerned.

The following editorial, entitled "Doctors Alert to Public Need," appeared in the January 14 issue of *The Indianapolis Star:*

"It is a tradition in the medical profession that a good physician is just as alert to prevent disease as he is to cure illness of his patients. That the people of this state have been aroused to a consciousness of the value of public health measures in general is due largely to the continuing efforts of the Indiana State Medical Association, recognized as one of the most effective in the nation. Its wise leadership is shown now in an offer of scholarships to recruit its ranks depleted during the war.

"Six or more of the $500 scholarships will be awarded annually in an effort to increase the number of physicians in small town and rural areas now without medical service. Students receiving this educational aid will pledge themselves to go into private practice in areas which a special committee will deem most in need of it.

"Dearth of doctors has reached serious proportions in various parts of Indiana. The ranks must be filled annually to offset the total of deaths and retirements. Small communities suffer from the trend to larger centers. Many who volunteered for war service located elsewhere after returning to private practice.

"Eighty-eight Hoosier doctors died last year and 296 moved to other states or retired. It takes about eight years to 'make' a doctor, so that steady accessions are essential to meet the state's demand.

"The doctors' program to spend their own money in service to Hoosierdom is highly commendable and deserving of aid from other sources. Another aim of the plan will be to foster more general practitioners and reduce the trend toward specialization. The Hoosier profession, in labor parlance, is endeavoring to increase the number of 'apprentices' to meet a public need."

The American Medical Association will celebrate its one hundredth anniversary at the annual meeting to be held in Atlantic City, June 9-13. It is well that this city has been chosen for the event, since no other spot in our nation could begin to take care of the thousands who will attend this celebration. In addition to native members of the parent organization, hundreds of persons from other countries will be there. Hotel accommodations will be at a premium and it is urged that all who plan to attend make their reservations right now. We would suggest that it might be well to make these through our Indiana headquarters office, rather than write directly to any of the hotels.

The American Social Hygiene Association avers that World War II syphilis may cost as much as a **billion dollars**! It also states that some 400,000 men entered the Army suffering from syphilis, or developed the infection soon after they entered service. The Navy figures are said to be along the same lines, though actual figures have not as yet been released. And, the most sordid feature of the report is that the infection rate is increasing, rather than decreasing. It is evident that more frank publicity must be given the problem; the people should be told, in plain language, just what the situation now is and just what it means. *This Week*, a small magazine included with week-end editions of many newspapers, recently published an authentic story that no doubt was read by several millions of our population. Among other items it related the story of a thirteen-year-old girl who had "distributed" venereal infection to about thirty-five men. This story was written by a V-D official, therefore it may be assumed to be authentic.

In our Convention Notes we stated that we saw Dr. A. C. Yoder, of Goshen, taking notes of the proceedings and wondered if we would be fortunate enough to receive a copy of his report to the home society. Sure enough, it came along and proved, as usual, to be a most interesting document. It covered all of the doings of the House of Delegates, with his usual clever comments on same. His notes on the annual registration fee law are uncommonly well put—he wants to see the bill before he fully makes up his mind about it. He, like many other members, has the notion that when the State of Indiana legally licenses an individual to practice the healing art said state should see to it that he behaves himself! The shortage of nurses problem also interested this delegate, no end; he quotes from a recent report by Doctor Gatch, to the effect that "more and more attention has been given to elevate the standards of nursing education, less and less emphasis has been placed on the care of the sick." Doctor Yoder appends to the copy of the report sent to us some "off the record" comments, all of which make interesting reading and offers a lot of things worth thinking about.

Many inquiries have been made as to just what the Cooperative Medical Advertising Bureau is—what does it do? Dr. Stanley Weld, editor of the Connecticut Medical Journal, recently addressed the Secretaries-Editors Conference on this subject. Doctor Weld is chairman of the Advisory Committee, and no man is better qualified to discuss the matter than he. In our March number, in an editorial, we will digest the remarks of Doctor Weld, thus enabling our members to understand just what the whole setup means and its value to the various state organizations.

The American Medical Association is sponsoring a new survey of the medical schools of the nation, the project having the support of the Association of American Medical Schools. It is a matter of ten years since such a survey has been made, hence we greet this move as one that will prove of incalculable benefit to American Medicine. This country is indeed fortunate in that the "Diploma Mills" of not so many years ago have been closed and that all but a very limited number of our medical schools are of the "approved" variety. We trust that the coming survey will serve to eliminate these few canker spots from our medical educational system.

The annual Live Stock Exposition, held in Chicago, has come and gone, leaving a generous sprinkling of its blue ribbons over the Hoosier State. Particularly did the Indiana 4-H boys and girls come through. Then, as a matter of course, the "Corn King" for 1946 hails from Indiana. For many years we have had this honor, even though some neighboring states have diligently tried to take this honor away from us. We were noting in a country weekly, published in our former home county, a story about the corn yield in that section; over one hundred bushels per acre in many places. This means a lot of money to the grower, whether he sells it in the market or feeds it to stock.

The Metropolitan Life Insurance Company, long known as being most vitally interested in health preservation matters, recently issued a brochure on "Studies in Heart Disease." Beginning with the comment that over **four million** citizens of this country are estimated to have some form of heart disease, the readers' attention at once is attracted. A chart showing age prevalence also commands one's attention; cases under the age of twenty are found in 3.8 per cent per 100,000. This rate increases with age, until the fifty to fifty-eight group shows 45.7 per cent, while the age group of eighty and over shows 241.6 per cent. Valvular heart disease in youths, according to figures taken from World Wars I and II, show a decline. In speaking of coronary thrombosis the report states that the great majority survive the first attack and most of them live for many years.

President's Page

Gentlemen, I Salute You!

ON December 6, just passed, I inaugurated a problem in clinical research in the all-so-human, group professional psychology of our organization in this great state. I was curious. On that date I "John Hancocked" and stuffed into the mail one hundred and forty-one letters of appointment to the standing committeemen of our association for the year 1947. Deliberately and with serious aforethought, studied omission was made of all reference to acceptance or refusal. Yes, I wanted to know! Something which I long suspected!

The result was amazing, even to me. A magnificent response! Immediately, day after day, letters arrived on my desk, letters which filled my cup of joy to overflowing, not for myself, but because of our great State Association, which we all hold in such high esteem.

Sample excerpts: "I appreciate the honor. . . ." "I shall cooperate in every possible way for the best interests of the profession." "I shall be happy to serve." "I accept and will make every effort to co-operate." "I shall do my best." "Any aid I can give will be gladly extended." ". . . to the utmost of my ability." "You may rely on my whole-hearted support." ". . . express my appreciation." ". . . am pleased for the chance."

Gentlemen, I never realized before that there were so many, nice, sincere ways of expressing unity of action and support, and there should be no wonder if we feel keyed to put forth every last effort on your behalf. It is a fitting reaffirmation of my prophetic words before the House of Delegates on October 29 last, when I said: "It could spawn only from a body of men whose ideals are the very highest." With a profound sense of responsibility, I uncover and bow most humbly in warm-hearted appreciation.

Gentlemen, I salute you!

BOX SCORE

Presidential appointees, 1947:

Non-veterans	38
Veterans World War I	47
Veterans World War II	46
No response to questionnaire	13

Gentlemen, that is balance, organization, representative distribution, power, irresistible power. Let's use it—rightly!

YOUR ORGANIZATION

The first tentative steps toward further streamlining of your organization's efficacy have been taken, and, as sentiment more fully jells, the efforts will be continued. Just a little push on the wheel.

Every senator and representative in the General Assembly, now in session, has been contacted over the signature of your president, and the letter is reproduced elsewhere in this issue. One more little push. This progressive idea originated with your amiable and efficient executive secretary, and it was collaborated in by the co-chairmen of your Committee on Public Policy and Legislation and by yours sincerely. If every county society could see its way clear to take similar action at the county level, that would constitute a series of little pushes, state-wide.

Your Council, Executive Committee, and the Committee on Public Policy and Legislation already are functioning with admirable smoothness. Other committees are working or are organized, on the alert, awaiting your directive to action. Phone or write your ideas and suggestions. Most usually my desk is cleared before sundown, sooner if urgent.

My evenings and Sundays—this is it.

Sincerely,

Floyd L. Romberger

AS IT LOOKS FROM COLORADO

H. T. SETHMAN

DENVER

"AS IT LOOKS FROM COLORADO," is one of the finest expositions of medical problems and the distribution of medical care we have read in many a day. We applaud Mr. H. T. Sethman, and we extend to The Wisconsin Medical Journal our gratitude for permission to reprint this splendid article.—*The Editors.*

COLORADANS are proud of their "wide open spaces," their scenery and great distances. On first thought one might not realize that mountain scenery forms a medical economic problem, but on careful study one finds that those tourist-bureau pictures of towering peaks and deep valleys pose the big problem of distributing medical care in this state.

Our cities have their problems, too, no different from yours in the Middle West. But when we put Rural Medical Care in capital letters and appoint a Commission, the average national student immediately pictures farms and villages and small trading areas and thinks of them in longitudinal miles crisscrossed by paved roads. Colorado's mountain miles are tortuous—and some of them are vertical! We have to consider a county bigger than some states (but with only 5,000 population), so split up by mountain ranges that when winter snows close the lesser passes, even the sheriff must travel 200 back-breaking miles through three other counties to go from his county seat to another town in his county only 30 air miles away. And we think of a certain valley supporting 1,000 souls where most of the thousand must travel 45 miles to the nearest doctor—or persuade him to come to them in whatever weather that rugged scenery cares to produce. Or we think of a certain "local" medical society whose 14 members average 48 miles each, every time they meet, and the average includes the two doctors in whose office the meeting is held.

It is a tough problem, but we don't want it solved from Washington. The medical profession, locally, is pointing the way to its solution and is insisting that the communities themselves have the potential power to do the job. Colorado's State Medical Society is breaking the problem up into its component parts and is explaining it to those most concerned. They, of course, are the leaders of farm and mining and ranching organizations. We are insisting that they are the ones who must act. They should use the voluntary pre-payment plans now available to ease their way financially and avoid loss of their freedom through national regimentation, yes; but neither voluntary nor compulsory sickness insurance will redistribute physicians. Distribution is their main difficulty, and when they ask why they cannot obtain a doctor for their community we tell them.

For instance: The very nature of modern medical education makes a city man of the young doctor even if he were reared in the country. His pre-medical education is in a medium-sized or large city. His medical school is in a city; so are most hospitals offering good internships and acceptable residencies. Every doctor about to begin practice has had at least seven, perhaps ten years of indoctrination in a certain "way of life." This includes daily contact with scores of other doctors, instant availability of the best in hospitals, medical equipment, laboratories, and libraries—not to mention the cultural advantages that cities offer to both him and his family.

The Author: A native of Denver, Mr. Sethman attended the University of Colorado, and worked for over eight years as a newspaper reporter, city editor, and political writer. Most of the year 1923 he spent on a world tour as a tourist conductor.

Since May, 1929, Mr. Sethman, a veteran of World Wars I and II, has been executive secretary of the Colorado State Medical Society and managing editor of the Rocky Mountain Medical Journal.

So the problem is not so purely financial as the do-gooders would have us think, and in this respect we believe Colorado is no different from many other states. In many "one-doctor-towns" where prepayment is neither desired or needed, lucrative practices go begging while city practitioners struggle to make both ends meet but will not consider moving to small communities. Rather than being financial, the conflict is one of inside plumbing versus the privy, modern family education versus the one-room school, paved streets between office and standardized hospital versus the kitchen table appendectomy by kerosene light, consultant in any specialty at the twist of a telephone dial versus 40 miles of quagmire to the next doctor, who, like as not, is out of town anyway on a call of his own.

We in Colorado see the problem of distributing medical care to rural families as having little to do with their ability or willingness to pay, because they are already both able and willing. We believe the basic trouble is simply the doctor's rightful insistence on decent facilities with which to practice good medicine the way he was taught to practice, plus his insistence on a decent place to live with his family.

Perhaps the threat of Wagner-Murray-Dingell-Pepperism will have been that proverbial darkest part of the night just before the dawn. A few streaks of light are beginning to show. A few rural leaders now admit that their lack of physicians is due in part to their towns' low standards of housing and sanitation. Others publicly state that poor

roads form a factor in their inadequate medical care, and add this argument to their push for highway construction. Still others are financing and drawing plans for community health centers and district hospitals and allied facilities to attract doctors, and are not waiting for the slow machinery of the Hill-Burton Bill. Rural health associations are being formed to join the surgical plan of Colorado Medical Service, Inc., the profession-sponsored voluntary non-profit prepayment plan which already covers almost a fourth of Colorado's urban population. These are signs, pointing the way.

Where low income groups have trouble paying the doctor and the hospital, voluntary pre-payment is our proposal as well as yours, and it is welcomed by the general public. But it still is only part of the answer.

Good medical care is just one feature of a high standard of living, and where standards of community living are adequate, so, with rare exceptions, is medical care. Neither federal law nor all the pre-payment plans can move a mountain range or make a doctor enjoy living in its valley. But an inspired and progressive local community can so raise its standard of living that the doctor will move into the valley and admire the mountain range as scenery rather than loathe it as a barrier. The self-seeking politician must be forced, and his horde of well meaning and misguided uplifters persuaded, to give Americans time to solve their medical problems by local evolution rather than national revolution. If thus given reasonable time from without, and supplied with vigor from within, medical guidance of community leadership will finish the job.

SOME CURRENT FEDERAL TAX PROBLEMS

TROY G. THURSTON*

INDIANAPOLIS

THESE comments are offered for the purpose of pointing out briefly some of the most common difficulties which arise in federal estate tax affairs.

In the average individual problem estate plans can be developed and followed which will help to assure that the beneficiaries will receive their proper shares in the estate with a minimum of loss through death taxes. But action for this purpose can be effective only if accomplished during the individual's lifetime.

Avoid the Double Estate Tax

Probably the first principle to be observed in estate planning is the avoidance of the second estate tax on the same property of a husband or wife. If the entire estate is caused to descend to the surviving spouse, it is subjected to a tax in the estate of such surviving spouse, in addition to the tax on the estate of the first decedent. While there is a substantial tax benefit available for a period of five years, by reason of the deduction allowable for property in an estate which has been subjected to tax in the estate of a prior decedent within the five preceding years, that benefit is completely eliminated after the end of the five year period. Further, the deduction for property so previously taxed within the five year prior period does not operate to eliminate the entire property from the taxable estate of the second decedent.

This situation becomes increasingly serious with advancing age of the married couple since both deaths become increasingly likely to occur within the space of a few years. The remedy is to avoid the passage of part or all of the estate to the surviving spouse. Equivalent benefit may be given to the surviving spouse by causing the property to be placed in trust, under control of the surviving spouse as trustee, or as adviser to the trustee, with the surviving spouse to be entitled to all or part of the income, as may be desired. In this way, it is possible for the surviving spouse to enjoy all the benefits of the property without actual direct ownership of the property and, accordingly, without increase in estate tax risk for the survivor's estate.

Avoid Excessive Joint Ownerships With Survivorship Rights

The federal estate tax is applicable where property is owned jointly in such manner that the survivor becomes the sole owner by reason of survivorship, excepting that if the surviving co-

* Mr. Thurston, a recognized tax authority, was invited to prepare an article on Federal Inheritance Taxes for the Indiana Medical Year Book issue, of January 1947. His article was received too late to be printed in that number, but because the subject is timely the editors decided to use his article in this issue. Mr Thurston is a member of the federal tax committee of the American Institute of Accountants and was formerly a lecturer on taxation at the Indiana University Extension Division.

owner can prove that part of the purchase price was furnished by him, the proportionate part of the value of the property may be excluded from the taxable estate of the first decedent. This places the full burden of proof upon the survivor to show satisfactory evidence of a contribution of part of the purchase price. Inequitable results frequently result from this requirement. In the case of jointly owned real estate or securities the property may have been owned for many years and the history of the purchase may not be traceable. In the case of a joint bank account the surviving owner may actually have deposited more in the account than the balance at the date of the death of the first to die, yet may be held not to have deposited the funds then on deposit because the balance in the account may have dropped to a low point at some prior time, after which all of the deposits were made by the decedent. If separate accounts had been maintained the decedent's estate would not be taxable upon the funds on deposit in the account of the survivor.

Where property is owned jointly, with survivorship rights, it is advisable that the situation be reviewed carefully to ascertain what action, if any, should be taken to produce a satisfactory status for estate and gift tax purposes.

It should be realized that the purchase of property, title to which is taken jointly with survivorship rights, constitutes a gift, for gift tax purposes, by the co-owner who furnishes the purchase price to the co-owner, who contributes nothing thereto. This effect results even though the property remains fully includable in the taxable estate of the co-owner who furnished the purchase price. Thus, the purchaser is accountable for the gift tax liability incident to the transaction and his estate will also be fully accountable for estate tax on the entire property. Often this type of situation can be improved by changing to a different form of ownership.

Life Insurance

The proceeds of life insurance are fully includable in the insured's taxable estate for federal estate tax purposes if the insurance was taken out by him. An exception is applicable if the insured had given away all incidents of ownership in the insurance prior to January 10, 1941. In general, insurance is not regarded as having been taken out by the insured if he has not paid the premiums directly or indirectly. If an insured has furnished the funds with which another pays the premiums on policies of insurance on the life of the insured, the insured may be regarded as having paid the premiums indirectly. But where such other person pays the premiums out of his separate income, such premium payments are not ordinarily classifiable as having been made indirectly by the insured.

The proceeds of insurance which are payable by reason of the death of the insured do not constitute taxable income to the beneficiary. If the proceeds are payable in the form of an annuity, either for life or a term certain, the beneficiary will receive aggregate amounts exceeding the amount which would have been payable in a lump sum at the death of the insured. Nevertheless, such extra amounts will not constitute taxable income to the beneficiary under present procedure. This feature gives added advantage to life insurance which is payable in the form of an annuity. The proceeds are not only received free from income tax but there is no reinvestment problem for the beneficiary.

Effective Reduction of Estate by Gifts

Property which is given away by an individual during his lifetime is excluded from his taxable estate, with certain exceptions relating to gifts which are made in contemplation of death or take effect at death. The gift tax applies to gifts which exceed allowable exemptions. Gifts are entirely excluded to the extent of $3,000 a year for each donee. For gifts exceeding this amount one lifetime exemption of $30,000 is available. Thus, if A gave $3,000 in money or property to each of his three children in the year 1946, no gift tax accountability resulted. If he then gives each of the three children $15,000 in 1947, the effect would be as follows:

Total gifts, 1947	$45,000
Exclusions—3 at $3,000	9,000
	$36,000
Exemption	30,000
Amount subject to tax	$ 6,000

If he should then give $15,000 to each of the three children in the year 1948, the entire amount of $36,000, representing the excess of gifts for the year over the exclusions of $9,000, would be subject to gift tax.

By appropriate action in spreading gifts over a number of years, substantial reductions in a taxable estate may be accomplished with a minimum of gift tax liability.

Maintain Identity of Inherited Property

As already stated, partial relief from double estate tax is available for a period of five years after a decedent's death. This relief depends upon identification of the inherited property in the second estate. The most common difficulty under this point relates to the identification of money or money received from the sale of other inherited property. While one who inherits property from another does not ordinarily contemplate that his own death will occur within a five year period, the maintenance of a clear identification of inherited property for such period of time is equivalent to a prepaid term life insurance policy for an amount equal to the estate tax which may be avoided by satisfactory identification of inherited property which will be fully taxed in the beneficiary's estate in the event of his death within five years if not separately identifiable.

Legislators Are Assured of Indiana Medicine's Support of Bills for Improving Public Health

Members of the state legislature were assured the full co-operation of the Indiana State Medical Association in enactment of bills for improving public health and medical practice, in a letter sent to them by Dr. Floyd T. Romberger, the president.

A copy of the letter follows:

"Better health conditions for the citizens of Indiana is a cardinal objective of the Indiana State Medical Association. Legislation now on the statute books which prevents disease, controls its spread and provides modern medical care for those who become ill has been recommended and sponsored by the medical profession.

"We know that you have only the best interests of the people at heart, and that in the forthcoming General Assembly you will want to support bills which will improve public health and medical practice.

"The Indiana State Medical Association has a committee to which you may turn for information about any proposed health legislation. This committee is going to study all bills on this subject carefully.

"Dr. Norman M. Beatty, 725 Hume Mansur Building, Indianapolis, (telephone Market 2688), and Dr. J. William Wright, 301 Hume Mansur Building, Indianapolis, (telephone Lincoln 1468) are co-chairmen of this Committee on Public Policy and Legislation. The committee members are: Drs. George Daniels, Marion; J. R. Doty, Gary; Harold J. Halleck, Winamac; O. T. Scamahorn, Pittsboro; Robert L. Glass, Indianapolis; John M. Palm, Brazil; Walter F. Kelly, Indianapolis, and A. N. Ferguson, Fort Wayne.

"Please feel free to call Doctors Beatty and Wright, and others on the committee, at any time you would like a digest of a bill affecting public health or the medical profession. Such information will be cheerfully given.

"During the ninety-eight years of its organized existence the Indiana State Medical Association has had cordial and co-operative relationship with the legislative body of our state. Our interest always has been most unselfish. Our organized effort has been solely in the interest of public health, and we earnestly desire to provide better and better medical care, year after year, to all the people.

"May I congratulate you upon the opportunity you have to render public service as a member of the legislature of our great state? I trust that you will enjoy your work as a member of this important law-making body.

"Very cordially yours,

"Floyd T. Romberger, M.D., President."

Indiana Salutes the Progress of American Medicine*

FLOYD T. ROMBERGER, M.D.

LAFAYETTE

THE physicians of the great sovereign state of Indiana proudly rise to stand side by side with the physicians of our sister states to salute the progress made in American medicine during the past one hundred years; American Medicine, practiced the American Way by free men, free physicians, collectively the best trained physicians in the world—today or any other day.

There reside in Indiana 3,992 physicians, of whom 3,446 are engaged in active practice. The membership of our Indiana State Medical Association is 3,502. Of these, 1,275, an unprecedented and a proud percentage, volunteered their services in the late war.

We staff and service 143 hospitals with a capacity of 33,747 beds. At no place within our borders, be it among the fertile farms of our countryside or the thriving industries of our cities, can there be found a lack of good medical care.

We have a physician-organized Mutual Medical Insurance, Inc.; it co-operates with the Blue Cross and is operating at high efficiency. Both the public acceptance thereof and its growth, entirely upon a voluntary plan, have been phenomenal.

During the recent emergency, the Indiana University School of Medicine graduated more physicians in one class than did any other medical school in the United States.

Our hospitalization is of the highest calibre.

Our Indiana State Medical Association, most fortunate in its leadership ever since its formation ninety-eight years ago, always has maintained cordial and happy relations with the people-selected members of our General Assembly.

Thus, the people themselves, all the people of this great sovereign state, all and at all times, benefit from good public health laws; laws formulated by a free and untrampled citizenry, laws written expressly in their own behalf, laws enacted in accordance with the truly fundamental principles of democracy—constitutional laws.

Most definitely in Indiana: "Ask and you shall receive; seek and you shall find"—good medical care.

*Address delivered over WIRE, Indianapolis, as part of the A.M.A.'s coast-to-coast broadcast, "Doctors Now and Then," January 25, 1947, following a dramatization of the first cholecystotomy, by Dr. John S. Bobbs, in 1868.

Medical Panorama by the Associate Editor

PHILADELPHIA MEDICINE thinks the recent sweeping victory of the Republican party is going to be all right for medicine, at least in their state, where the candidates "stood upon a pledge of total opposition to any form of socialized medicine."

S
I M A

SAN DIEGO COUNTY Medical Society is to be congratulated upon their new Bulletin. Many items of local, as well as of national interest appear, and the format is generally attractive. A recent addition of an executive secretary has been of value in the introduction and execution of work that is often too much for the busy doctor or part-time secretary.

S
I M A

PITTSBURGH MEDICAL BULLETIN quotes, "The true danger is when liberty is nibbled away, for expedients, and by parts."—Burke. The old pincer movement!

S
I M A

MEDICAL SOCIETY COUNTY OF ERIE and the Buffalo Academy of Medicine, in a recent Bulletin, announce that physicians will be paid ten dollars for delivering talks on cancer before lay audiences, payment to be made by the State Department of Health.

S
I M A

GREEN COUNTY (ILLINOIS) MONTHLY Bulletin's "Ozark Doc" says, "Paying dues into your medical society, whether the dues be $50 a year or $100, alone will not make a medical society. It takes attendance at meetings, enthusiasm, and hard work by all the members to do it. Your professional organization can never thrive on indifference. It must not play second fiddle to anything else. In some of the labor unions attendance at meetings is required. With physicians, compulsion should not be necessary—if they have any passion for the science of modern medicine."

S
I M A

AMERICAN HEART ASSOCIATION will inaugurate a nationwide program of public education and information on diseases of the heart. An estimated 4,000,000 people in the United States have heart disease. Cardio-vascular diseases accounted for 575,000 deaths in 1944. "The dissemination of educational information to the public in a broad effort to retard the rapid increase of heart disease throughout the nation," is the primary purpose of the campaign.

MEDICAL BULLETIN of Sedgwick County Medical Society says, "In the final analysis the building of a successful practice depends not only upon scientific attainment but also upon the friendship and esteem of the general public, commonly known as 'public relations'—it takes a lot of doing."

S
I M A

WEST VIRGINIA MEDICAL JOURNAL comments at length on Harold E. Stassen's "Program for Progress." One quote: "The program" (re: National health problems) "will be based squarely upon the existing medical and hospital insurance plans and will not disrupt these as the presently proposed national legislation would." They suggest adding the item of a department of health, with a doctor of medicine secretary, of cabinet rank.

S
I M A

JOURNAL OF THE KANSAS Medical Society considers assigned debate topics to high schools and colleges of enough importance to present a statement by the Kansas Medical Society, a statement by the Kansas Hospital Service Association, Inc., and a statement by Kansas Physicians' Service—all setting out many valuable points. Remember the topic? "Resolved: that the Federal Government should provide a system of complete medical care available to all citizens at public expense." Better get your arguments together. For reference see: "Compulsion—The Key to Collectivism," and A.M.A.'s "Voluntary Health Insurance versus Compulsory Sickness Insurance."

S
I M A

ACADEMY OF MEDICINE of Toledo and Lucas County, in their Bulletin, make a strong plea for good medical advertising. In part, "Organized medicine at State and National levels ought to make concentrated efforts to get the constructive points of medicine before the public. We are not asking for an advertising program or a cheap sales promotion scheme. We are asking that medicine be 'FOR' more things that are constructive and progressive and will get results, and that it spend less time being 'AGAINST' the inferior product. Use all our good points (and they are legion) to a better advantage, improve the product and keep it forever salesworthy. Tell and sell the public the good points. Be more 'FOR' and 'FOR' more."

What's Going On In Indiana by the Executive Secretary

Council Elections. Dr. Alfred Ellison, of South Bend, was elected by the Council as its chairman at the January meeting. He succeeds Dr. A. M. Mitchell, of Terre Haute, who has been moved to a higher field. Doctor Mitchell will serve as secretary of the committee named by the board of trustees of the American Medical Association to arrange for the first nation-wide conference of county medical society officials at Atlantic City. The meeting will be held Sunday, June 8, the day before the opening of the annual A.M.A. session. Dr. Walter L. Portteus, of Franklin, was elected a member of the Executive Committee, to succeed Dr. Cleon A. Nafe, president-elect. Dr. C. H. McCaskey was re-elected to the committee.

——ISMA——

Annual Session Dates. Dates for the annual state session have been set for October 28, 29 and 30, and French Lick is the place. Under its new management many improvements are planned at the French Lick Springs Hotel. The American plan of operation will be retained. As it will be necessary to use West Baden hotels to accommodate everybody, those desiring to be in the French Lick Springs Hotel should write for reservations early. The instructional courses and stag party will be held on Tuesday, October 28, as usual. The general scientific meeting will extend through all day Wednesday, October 29, with the dinner program that evening. On Thursday morning, October 30, sectional meetings and the last meeting of the House of Delegates will be held. This will be virtually a three-day meeting instead of the usual two days, and it will keep from crowding events.

——ISMA——

Senator Jenner's Appointment. Hoosier medicine was happy to read that United States Senator William E. Jenner was appointed to the Committee on Labor and Public Welfare. This is the committee to which the former Wagner-Murray-Dingell bill was referred and which held hearings on it last spring and early summer. As a plank in the Republican party's platform opposed "unequivocally" to the proposed socialization of the practice of medicine, Senator Jenner can be relied upon to fight such a movement. Word is that the sponsors of compulsory health insurance will have a revised Wagner-Murray-Dingell bill introduced at this session of Congress, but chances of its getting beyond the committee stage are slim.

Enrollment Hits 100,000. January 15, 1947, was a milestone in Indiana medicine's program of prepaid medical care. On that date one hundred thousand persons were covered by the "Doctor's Plan," a remarkable feat when one thinks that a year ago—January 15, 1946—the House of Delegates had not yet authorized the establishment of Mutual Medical Insurance, Inc. More than eighty plans of voluntary prepayment medical care are now in operation in thirty-three states, Hawaii and Puerto Rico. In addition, thirteen states and the District of Columbia are developing plans. Just two states (both in the South) do not have programs in the process of formation. Five million persons now have medical coverage on the voluntary basis. Speakers to explain the Indiana company's operation in particular, and the national program in general, will be supplied upon request. The Mutual Medical Insurance, Inc., address is 700 Test Building, Indianapolis 4.

——ISMA——

Medical Scholarships. The press has carried articles telling about the action of the Council January 12 in providing scholarships of $500 each to help worthy young men and women procure a medical education. The student who accepts a scholarship must agree to practice for a limited time in some area of Indiana which is in need of medical service. Dr. Floyd T. Romberger, association president, appointed Dr. Cyrus J. Clark, of Indianapolis, as chairman of the Scholarship Committee. Others on the committee are Drs. N. K. Forster, of Hammond, M. R. Lohman, of Fort Wayne, and Herman T. Combs, of Evansville. This move by the profession to produce more physicians for Indiana and help alleviate the shortage of doctors in rural areas brought immediate commendation. Said *The Indianapolis Star* editorially: "That the people of this state have been aroused to a consciousness of the value of public health measures in general is due largely to the continuing efforts of the Indiana State Medical Association, recognized as one of the most effective in the nation. Its wise leadership is shown now in an offer of scholarships to recruit its ranks depleted during the war . . . The doctors' program to spend their own money in service to Hoosierdom is highly commendable."

Military News

Dr. Charles M. Bowman has resumed the practice of medicine and surgery in Albion, following his recent discharge from the Armed Forces.

Announcement has been made by Dr. Lester D. Bibler, of the opening of an office for the practice of general medicine in Suite 811, Underwriters Building, in Indianapolis. Doctor Bibler is a veteran of six years' naval service.

Dr. Robert Cornell, who served overseas with the Army Medical Corps for almost three years, has opened an office for the practice of medicine and surgery in Crawfordsville. Doctor Cornell completed his Army service on August 17, 1946. He has recently been promoted to major in the Medical Reserve Corps.

After having served for two and one-half years in the Army, Dr. James W. Young, of Indianapolis, has announced the opening of an office for the practice of medicine at 6302 Guilford Avenue. Doctor Young was a captain at the time of his discharge. He spent ten months with General Patton's Third Army and served at Metz and in the battles of the Bulge and the Rhine. He received the Bronze Star Medal.

Captain Donald H. McCartney, of Fairmount, who recently was separated from the service, is now associated with Dr. Frank W. Teague, at 501 Hume Mansur Building, in Indianapolis, in the practice of orthopedics. Doctor McCartney entered the Army in July, 1944, at Carlisle Barracks, Pennsylvania. From there he went to the Walter Reed General Hospital, in Washington, D.C., where he was on orthopedic service. His terminal leave expired December 13, 1946.

Major Lewis G. Jacobs, formerly of Indianapolis, has located permanently in Oakland, California, following his recent release from the service. He is at the Oakland Regional Hospital there. Doctor Jacobs entered the service March 20, 1944, and went to the William Beaumont General Hospital, at El Paso, Texas, where he remained for approximately eight months, as chief of the radiation therapy center. He then was transferred to Ashburn General Hospital, at McKinney, Texas, where he served as radiologist, and then to Bruns General Hospital, in Santa Fe, New Mexico, where he was chief of the x-ray department. He was separated from service at Santa Fe, his terminal leave having ended on January thirtieth.

Dr. Jesse W. Bowers, having completed more than five years service in the Armed Forces, has re-opened his office in Fort Wayne.

Dr. Edwin E. Gregg has announced the opening of an office in Thorntown for the practice of medicine. Doctor Gregg served in the army with the rank of Captain.

Dr. Chester A. Stayton announces the association of Dr. George W. Ritteman in the practice of radiology at 313 Hume Mansur Building, Indianapolis. Doctor Ritteman completed five years service in the United States Army, and was discharged with the rank of major.

After four years' military service, Dr. Clayton L. Rice has announced the opening of an office for the practice of medicine and surgery in Greenfield. Following his separation early this year Doctor Rice was anesthetist for a few months at the Major Hospital and Inlow Clinic, in Shelbyville.

Captain Richard H. Gwartney, formerly of Muncie, recently has been promoted. He is the Chief of Medical Service at the 55th Station Hospital of Peninsular Base Section, the Army Service Force in Italy. The Base was the important service and supply organization for the Fifth Army and for the ground forces of the United States Air Corps and Navy in the Mediterranean Theatre of Operations, during combat.

Before entering military service, Capt. Gwartney was the Resident Physician at Ball Memorial Hospital at Muncie.

Formerly of Fort Wayne, Lieutenant W. E. Grodrian has moved his family to Silverton, Oregon, where he has begun the general practice of medicine, following his recent release from the service. Doctor Grodrian entered the Navy February 14, 1944, at Great Lakes, Illinois. After spending about a month there, he was transferred to the Acorn Training Detachment, at Port Hueneme, California, where he remained for three months. From there he went to Camp Pendleton, California, with the Marine Corps, and then overseas on August 14, 1944. He served for eighteen months on Guam and Iwo Jima, with the 3rd Marine Division. While on Guam he frequently saw Dr. Woodson Young, of Indianapolis, who was attached to the Native Hospital there. For four months prior to his separation from service Doctor Grodrian served as senior medical officer at the Marine Separation Center at Great Lakes.

News Notes

Announcement has been made by Dr. Alex F. Craig of the opening of an office in Knightstown, for the practice of medicine.

Dr. W. A. Van Nest has closed his office in Ashley and moved his equipment to New Smyrna Beach, Florida, where he has taken over the operation of a hospital.

Dr. Thomas A. O'Dell, who has been a practicing physician in the same community in Indianapolis for the past forty-seven years, has retired, and plans to spend the winter in Fort Lauderdale, Florida.

Southeastern Surgical Congress Meeting

The fifteenth annual assembly of the Southeastern Surgical Congress will be held in the Brown Hotel, in Louisville, Kentucky, on March 10, 11 and 12. Thirty-one prominent physicians, from all over the United States and Canada, will appear on the program.

Third Annual Clinical Conference Chicago Medical Society

March 4, 5, 6 and 7

The 1947 Conference Committee has endeavored to surpass the success of preceding Clinical Conferences, and have arranged for well-known medical men to present subjects of appeal to all physicians, but particularly to the general practitioner. Outstanding scientific and commercial exhibits have been selected, and a prominent national speaker has been invited to the banquet.

Fellowship in A.M.A.

The American Medical Association will celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration. Only Fellows and invited guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A.M.A. Fellowship dues and subscription to *The Journal of the A.M.A.* are both included in one annual payment of $8.00, which is the cost of The Journal to subscribers who are not Fellows. If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association, 535 North Dearborn Street, Chicago 10, and ask if you are eligible to become a Fellow.

Dr. George A. Collett, who has practiced surgery in Crawfordsville for the past twenty years, has recently gone to Elko, Nevada, where he will become associated with the Elko clinic.

The Indiana University Chapter of Nu Sigma Phi, women's medical sorority, will be host at the national convention of the sorority to be held at the Hotel Severin, Indianapolis, on February fifteenth and sixteenth. All members are urged to attend.

Fellowships for Physicians

Announcement is made by Surgeon General Thomas Parran of the United States Public Health Service that applications for Fellowships in postgraduate public health training for physicians for the school year beginning in the fall of 1947 will be received at any time prior to May 1, 1947.

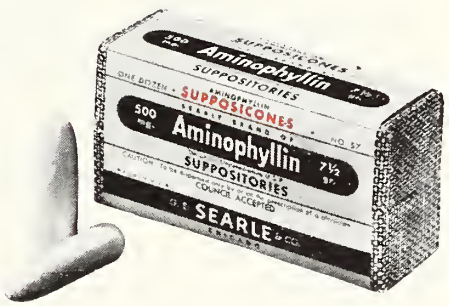
The Fellowships are made possible by a grant of $228,400 from the National Foundation for Infantile Paralysis through funds contributed to its March of Dimes. Fifty-three students were awarded Fellowships for the school year beginning in September 1946.

The Fellowships provide an academic year's graduate training of approximately nine months in an accredited school of public health, followed by three months of field training, and are open to men and women, citizens of the United States, under forty-five years of age. Physician applicants must have completed at least a year's internship. The Fellowships are administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association, and the United States Public Health Service.

The specific purpose of the Fellowships is to aid in the recruitment of trained health officers, to help fill hundreds of vacancies existing in state and local health departments throughout the country. The Fellowships are intended for newcomers to the public health field, and are not open to employees of state and local health departments, for whom Federal grant-in-aid funds are already available to the states.

Applicants for Fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, 19th and Constitution Avenue, N. W., Washington 25, D. C., Attention Public Health Training.

for prolonged optimum effect:



Aminophyllin Supposicones

(SEARLE BRAND OF AMINOPHYLLIN SUPPOSITORIES)

The improved Aminophyllin Supposicone developed by Searle Research provides an excellent vehicle for prolonged and complete absorption of the contained medicament (7½ gr. of Searle Aminophyllin*).

Supposicones are unlike all suppositories known heretofore—the specially prepared base results in prompt disintegration in the rectum at body temperature, yet no refrigerated storage is necessary.

Aminophyllin Supposicones are nonirritating to the rectal mucosa—no anesthetic is required—and they are properly sized and shaped for easy insertion and retention.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

In boxes of 12.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

NOTICE!

Ciba Medical Slyd-Rul Incorrect

Due to manufacturers' error in placement of decimal point, conversion from 0.4 grain to gram is incorrect. It should read 0.025 gram, not 0.25. Please make correction by replacing present celluloid table with corrected temporary paper table now being mailed to you.

Ciba will replace the temporary slide with a new celluloid table as soon as possible.

Art Contest Deadline

May 1, 1947, is the deadline for entering the $34,000 prize art contest on the special subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians in war and in peace). This contest is open to all physicians in the Western Hemisphere. The exhibition will take place in conjunction with the A.M.A. Centennial Session at Atlantic City, June 9-13, 1947. For complete information, write to Francis H. Redewill, M. D., Secretary, American Physicians Art Association, Flood Building, San Francisco, California, or to the sponsor, Mead Johnson & Company, Evansville 21.

INDIANA UNIVERSITY NEWS NOTES

Dr. Donald J. Caseley, Indianapolis orthopedic surgeon and member of the staff of General Hospital 32, has been made acting medical director of hospitals at the Indiana University Medical Center.

As acting medical director, Dr. Caseley will have general supervision of the three hospitals at the University Medical Center—the William H. Coleman Hospital for Women, the James Whitcomb Riley Memorial Hospital for Children, and the Robert W. Long Hospital. A native of Sullivan, Illinois, he received the A.B. degree from DePauw University in 1933 and was graduated from the Indiana University Medical School in 1937.

Dr. Caseley served his internship at the Indianapolis City Hospital and for three years prior to the War was a resident in orthopedic surgery at the Indiana University Medical Center. Entering military service with the 32nd General Hospital, which was sponsored by the medical center, he later was chief of the orthopedic section, 347th Station Hospital, and 121st General Hospital in the European Theatre, and was assistant chief, orthopedic section, of Tilton General Hospital, Fort Dix, New Jersey, prior to separation from service as a major.

Dr. Caseley succeeds Dr. John D. Van Nuys, who has been made executive secretary of the Indiana University School of Medicine.

Deaths

Warren H. Ristine, M.D., of Crawfordsville, died on December fifth, in Lakeland, Florida, following an illness of several months. He was ninety-six years of age. Doctor Ristine graduated from the Bellevue Hospital Medical College, in New York, in 1877, and had practiced medicine in Crawfordsville for more than half a century. He had been retired for several years.

* * *

Earl Van Reed, M.D., of Lafayette, died suddenly at his home on October tenth. He was sixty-seven years of age. Doctor Van Reed graduated from the Medical College of Indiana, in 1905, and since then had practiced in Lafayette. He served as secretary of the Tippecanoe County Medical Society from 1912 to 1916, inclusive. During World War I he served in the Army Medical Corps, with the rank of first lieutenant. Doctor Van Reed was a member of the Tippecanoe County Medical Society, the Indiana State Medical Association and the American Medical Association.

Lloyd O. Sholty, M.D., of Lafayette, died at his home, on December twenty-fourth, after an illness of two months. He was sixty-two years of age. Doctor Sholty was a graduate of the Indiana University School of Medicine, Indianapolis, in 1912, and was a member of the Tippecanoe County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

Francis V. Martin, M.D., of Michigan City, died suddenly in the Clinic Hospital in Michigan City, on December thirteenth, at the age of eighty-two years. He graduated from the University of Michigan Homeopathic Medical School, in Ann Arbor, in 1892. For over half a century Doctor Martin had practiced medicine in and near Michigan City, and he was a pioneer in roentgenology. He was a member of the Radiological Society of North America, Inc., the LaPorte County Medical Society, in which organization he had held several offices, the Indiana State Medical Association, and a Fellow of the American Medical Association.



Top-rank chemist . . .

Dietary Dub!

His work is performed with infinite care . . . But he chooses his meals on whim. He eats only the foods he likes—a choice of notably limited range. The inevitable result is a further increase in the ranks of the self-made victims of borderline vitamin deficiency. You know many of them: the ignorant and indifferent, patients "too busy" to eat properly, those on self-imposed and badly balanced reducing diets, excessive smokers, alcoholics, and food faddists, to name but a few. First thought in such cases is dietary reform, of course. But this is often more easily advised than accomplished. Because of this, an ever-growing number of physicians prescribe a vitamin supplement in every case of deficiency. If you're one of these physicians—or if you prescribe vitamins only rarely—consider the advantages of specifying an *Abbott* vitamin product: Quality—Certainty of potency—A line which includes a product for almost every vitamin need—And easy availability through good pharmacies everywhere. ABBOTT LABORATORIES, North Chicago, Illinois.

Specify: **Abbott Vitamin Products**

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Indiana's Oldest Practicing Physician Dies

Wilson T. Lawson, M.D., of Danville, died on December fourteenth, at St. Vincent's Hospital, in Indianapolis, at the age of ninety-seven years. He was a graduate of the Miami Medical College, in Cincinnati, in 1878, and had been a practicing physician in Danville for over a period of sixty-eight years. He served as coroner of Hendricks County from 1927 to 1933, was county health officer from 1924 until his death, and was secretary of the Hendricks County Medical Society for over forty years. He also had served as vice-president of the Indiana State Medical Association in 1923. He was a member of the Hendricks County Medical Society, the Indiana State Medical Association, and the American Medical Association.



Wilson T. Lawson, M.D.

* * *

Earl Palmer, M.D., of Logansport, died at the Cass County Hospital on November twenty-fourth. He was sixty-four years of age. Doctor Palmer was a graduate of the Rush Medical College in 1906 and specialized in neurology and psychiatry. He was a former superintendent of the Logansport State Hospital and had practiced medicine in Logansport for forty years. Doctor Palmer was a member of the Cass County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

Joseph C. Reeder, M.D., of Montezuma, died on November twenty-eighth, at his home, at the age of ninety-one. Doctor Reeder was a graduate of the Eclectic Medical College in Cincinnati in 1886 and for sixty years he had practiced medicine in Montezuma and neighboring communities.

* * *

George M. Freeman, M.D., of Shoals, died on December twentieth, at the Daviess County Hospital in Washington, after an extended illness. He was seventy-nine years of age. Dr. Freeman was a graduate of the Kentucky School of Medicine, in Louisville, in 1890, and had been a practicing physician in Shoals for fifty-six years.

* * *

Harman R. Goldthwaite, M.D., of Marion, died suddenly at his home on December eighth, at the age of fifty-three years. He graduated from the Temple University School of Medicine, in Philadelphia, in 1922. Doctor Goldthwaite specialized in internal medicine. For the past several years he had been school physician in Marion. He was a member of the Grant County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Frank T. Kilgore, M.D., of Yorktown, died on December twenty-second, at the Ball Memorial Hospital in Muncie, following a long illness. He was seventy years of age. Doctor Kilgore was a graduate of the Medical College of Indiana, in Indianapolis, in 1898, and had practiced in Ingalls and Daleville before going to Yorktown twenty-nine years ago. He served as coroner from 1925 to 1929 and was a veteran of World War I, where he attained the rank of lieutenant colonel. Doctor Kilgore was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Perlee W. McCarty, M.D., of Indianapolis, died on December twenty-third, at his home, at the age of seventy-six years. Doctor McCarty graduated from the Medical College of Indiana, in Indianapolis, in 1904, and had been practicing medicine in Indianapolis for the past forty years.

THIRD INDUSTRIAL HEALTH CONFERENCE ON APRIL 16

The Committee on Industrial Health of the Indiana State Medical Association has announced that the third industrial health conference open to all physicians will be held Wednesday, April 16, 1947, at the Indiana University School of Medicine, Indianapolis. The Department of Public Health of the medical school is co-operating with the committee in sponsoring the program.

Some of the biggest men in the industrial medicine field have accepted invitations to participate in the program, including Henry Kessler, M.D., of Newark, New Jersey; L. E. Hamlin, M.D., Chicago; L. F. Weber, M.D., Chicago; Dr. Lawrence Fairhall, Bethesda, Maryland, and Dr. Ann Baetjer, Baltimore, Maryland.

The conference will begin at 9:30 a.m. with registration and conclude at 4:45 p.m. after a discussion of the papers. The entire conference program will be printed in the March issue of THE JOURNAL.



Sturdy
ON STRONG FOUNDATIONS

The 2000 year old Nile Temple of Philae stands enduringly firm on its original foundation—even though flooded each year from November to June, since the construction of the Assuan Dam at the end of the nineteenth century. • Similarly, for sturdy bodies in later years a strong nutritional foundation must be established early in infancy. • For this assurance, BIOLAC safely and simply furnishes nutritional elements for optimum health. Among the other essential nutrients are valuable proteins of milk, an outstanding source of *all the essential amino acids* ...the indispensable foundation stones for sound tissues. • Indeed, BIOLAC is "baby talk" for a good square meal.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE • NEW YORK 17, N. Y.

ACCEPTED AMERICAN MEDICAL ASSN.

Biolac

The foundation is the thing!



Biolac is a liquid modified milk, prepared from whole and skim milk with added lactose, and fortified with thiamine, concentrate of vitamins A and D from cod liver oil, and iron citrate; only Vitamin C supplementation is necessary. Evaporated, homogenized and sterilized. Available in 13 fl. oz. tins at all drug stores.

Quickly prepared...easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.

Society Reports

EXECUTIVE COMMITTEE

December 1, 1946.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: Norman M. Beatty, M.D., and J. William Wright, M.D., co-chairmen, Committee on Public Policy and Legislation.

Membership Report

Number of members November 30, 1946	3,486*
Number of members November 30, 1945	3,380
Gain over last year	106

* Includes 877 in military service, 352 World War II veterans, and 155 honorary members.

Treasurer's Office

Annual Audit

On motion of Dr. McCaskey, seconded by Dr. Ferrell, the George S. Olive and Company is to be employed to make the annual audit of the books.

Legislative Matters

Local

Dr. Beatty and Dr. Wright, co-chairmen of the Legislative Committee, discussed problems pertaining to the coming session of the legislature.

Statements of receipts and expenditures for September, October and November for the Association committees and for October and November for THE JOURNAL were approved.

1946 Annual Session, Indianapolis, October 29, 30, 31, 1946

On motion of Dr. Mitchell, seconded by Dr. Ferrell, the expenditure of $60.40 was authorized from the receipts from the annual dinner to frame the service flag to be placed in the headquarters office.

The chairman of the Committee on Convention Arrangements, in submitting his report, recommended that state meetings in the future be extended one day; there is too much to be crowded into the present two-day session.

1947 Annual Session, French Lick

Date of Meeting

By common consent it was voted to hold the 1947 annual session on October 28, 29 and 30, at French Lick.

Clarification of Exhibitors' Standards

The executive secretary was directed to find out the procedure used in other states in determining the eligibility of commercial exhibitors to space at the annual session.

Organization Matters

The committee designated Dr. Romberger as the representative of the Indiana State Medical Association to participate in the coast-to-coast A.M.A. broadcast, "Doctors Now and Then," on January 25, 1947, over WIRE, Indianapolis.

Committee selections for 1947 were discussed by the president-elect.

Sister Elizabeth Kenny Foundation

Upon the motion of Dr. Mitchell, seconded by Dr. Ferrell, the committee supported the opposition of the Indianapolis Medical Society against the Indiana campaign for funds for the Sister Elizabeth Kenny Foundation for Infantile Paralysis.

Memorial to Nurses

Upon the motion of Dr. Romberger, seconded by Dr. Ferrell, the request received by the president of the association for appointment of an Indiana chairman to head a campaign for funds to erect a memorial in Washington, dedicated to nurses of the Armed Forces, World War II, was referred to the executive secretary for clearance through the Indiana State Nurses Association.

Indiana Board of General Practice of Medicine, Inc.

On motion of Dr. McCaskey, seconded by Dr. Ferrell, the Indiana Board of General Practice of Medicine, Inc., was to be asked to establish headquarters outside the association offices. (Later, the president of the Board appeared before the committee and reported that plans were under way to place the activities of this Board under the secretary-treasurer of the Board.)

Physicians' Signatures on Death Certificates.

On motion of Dr. Mitchell, seconded by Dr. McCaskey, the executive secretary was directed to call attention in his column in THE JOURNAL to the fact that the law requires physicians themselves to sign death certificates and that all physicians be urged to co-operate with funeral directors. Physicians should not permit their names to be signed to death certificates by proxy, as this procedure is illegal.

Allowances for Traveling Expenses

Upon the motion of Dr. Mitchell, seconded by Dr. Ferrell, the officers of the association and lay employees of the association are to be allowed 5 cents a mile when using their own automobile, and actual traveling expenses. The mileage allowance also pertains to committee members in attending committee meetings.

Educating the public to "see your doctor"

This is No. 201 in the Parke-Davis series of messages published in the interest of the medical profession. Appearing in color in LIFE and other leading magazines, it will reach an audience of over 23 million people.

Some things you should know about sulfa

No. 201 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



Suppose you have a sore throat.

A friend may tell you how a bad sore throat was cured with a few sulfa tablets—may even offer you some and suggest that you try them.

To do so would be extremely unwise.

For your friend may have had a type of infection against which sulfa is often miraculously effective. *Your* sore throat may be of a kind on which sulfa has no effect whatever.

In any case, taking sulfa drugs without the guidance of a physician is a far more hazardous procedure than most people realize.

If you take sulfa for a minor ailment, for instance, you may become sensitive to the drug itself. Then if you should later have a serious illness, your doctor might find it unwise to prescribe sulfa for your case.

When you dose yourself with sulfa, you may also run the risk of kidney ailments, anemia, and other blood diseases. This is why in many states the law specifies that sulfa drugs may be dispensed only on a physician's prescription.

Your doctor is the only person competent to judge whether your ailment is one which responds to treatment with sulfa, and whether your ailment is serious enough to warrant the use of sulfa. He alone knows which of the various sulfa drugs to use, how much to give, what precautions to take.

SEE YOUR DOCTOR. What is true of treating illnesses with sulfa is true of any form of treatment. Don't take a friend's suggestion. Don't prescribe for yourself. At the first sign of illness see your doctor. He is the one person qualified to advise you on the vital questions which concern your health.

Makers of medicines prescribed by physicians

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Future Medical Meetings

Conference of State Secretaries and Editors, Chicago, December 7 and 8, 1946.

A.M.A. House of Delegates, Chicago, December 9-11, 1946.

The Journal

Report on Advertising

Additions	$ 291.89
Decreases	153.22
Total increase during November	$ 138.67
Total increase over budget estimate, 1946	$5,891.48

Printing Costs for 1947

Letter from C. E. Pauley and Company, Inc., giving the costs of printing THE JOURNAL, effective January 1, 1947, was submitted by the managing editor.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

January 5, 1947.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: Norman M. Beatty, M.D., and J. William Wright, M.D., co-chairmen, Committee on Public Policy and Legislation.

Membership Report

Number of members December 31, 1946	3,500*
Number of members December 31, 1945	3,390
Gain over last year	110

* Includes 892 in military service (gratis); 355 World War II veterans ($10.00); 155 honorary members.

Treasurer's Office

Annual Audit. The treasurer reported that the books of the association were being audited by George S. Olive and Company and that the report would be ready for presentation to the Council on January 12.

Investments. The Executive Committee authorized the treasurer to invest the $5,000.00 received from matured Treasury Bonds in United States Savings Bonds, Series G, with a yield of 2.50 per cent.

Statements of receipts and expenditures for December for the Association committees and THE JOURNAL were approved.

1947 Annual Session, French Lick, October 28, 29, 30, 1947

Clarification of exhibitors' standards. By common consent it was decided not to change the rule governing commercial exhibits. The executive secretary was directed to submit the applications of questionable exhibitors to the Executive Committee for acceptance or rejection.

Legislative Matters

Local

Drs. Beatty and Wright discussed 1947 state legislative problems.

The attorney read the proposed annual registration bill which will be introduced in the 1947 General Assembly in accordance with instructions from the House of Delegates.

National

Letter from national commander of the American Legion, acknowledging resolution of appreciation for Legion's action against compulsory health insurance, was read.

Organization Matters

New expense voucher allowing actual traveling expenses, instead of $5.00 per day, to association officers and committeemen, was adopted.

Letter from Ora L. Wildermuth, president, Board of Trustees, Indiana University, read.

Executive secretary reported that the secretary-treasurer of the Indiana Board of General Practice of Medicine, Inc., was taking over the board's affairs by action of the board's directors.

Future Medical Meetings

Industrial Health Conference, Indiana University School of Medicine, April 16, 1947.

THE JOURNAL

The managing editor reported that $1,028.00 worth of advertising had been obtained through letters mailed out at a cost of $37.79, and that the January issue contained eight pages more of advertising than any previous issue of THE JOURNAL.

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

December 2, 1946

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following news releases for "Hints on Health" were approved:

Week of December 23, 1946—"Heart Murmurs."

Week of December 30, 1946—"Vaccination 'Musts.'"

The secretary presented the public relations programs of the Oklahoma and Michigan State Medical Associations.

Debate material supplied by the Council on Medical Service of the American Medical Association was reviewed.

Speakers procurred:

December 3, 1946—Boone County Medical Society, Lebanon. "Streptomycin."

IT IS
GOOD PRACTICE

. . . in judging the irritant properties of cigarette smoke . . . to base your evaluation on scientific research. In judging *research,* you *must* consider its *source**.

PHILIP MORRIS claims of superiority are based *not* on anonymous studies, but on research conducted only by competent and reliable authorities, research reported in leading journals in the medical field.

Clinical as well as laboratory tests have shown PHILIP MORRIS to be definitely and measurably less irritating to the sensitive tissues of the nose and throat. May we send you reprints of the studies?



PHILIP MORRIS

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

BUREAU OF PUBLICITY

December 16, 1946.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

A news release entitled "Yule Happiness Jeopardized by Threat of Fire," for distribution to daily and weekly newspapers, was approved.

The bureau directed the secretary to send a pamphlet "Ways of Meeting Costs of Illness," issued by the Research Council for Economic Security, to the Committee on State Fair for consideration for distribution at the 1947 state fair.

A folder issued by the Medical Society of the State of New York, on compulsory health insurance, entitled "Check and Double Check on Sickness Insurance," was reviewed.

The secretary was instructed to make a survey of the high schools in Indiana which have debate teams and send a list of them to the Council on Medical Service of the American Medical Association, which promised the bureau to mail each school debate coach literature setting forth arguments against compulsory health insurance.

The secretary reported that a quantity of information against proposed government medicine had been supplied Mr. Shoemaker, the debate coach of Shortridge High School in Indianapolis.

LOCAL SOCIETY REPORTS

100 PER CENT IN PAYMENT OF 1947 DUES

Clinton County
Gibson County
Harrison County
Jasper-Newton County
Jennings County
LaGrange County
Noble County
Posey County
Washington County

COUNTY MEDICAL SOCIETY OFFICERS

ALLEN (Fort Wayne) COUNTY MEDICAL SOCIETY
President, Arthur N. Ferguson, Fort Wayne,
Vice-President, Richard H. Miller, Fort Wayne,
Secretary, Orval J. Miller, Fort Wayne,
Treasurer, Robert H. W. Brosius, Fort Wayne.

BARTHOLOMEW-BROWN COUNTY MEDICAL SOCIETY
President, Richard K. Schmitt, Columbus,
Vice-President, Byron K. Zaring, Columbus,
Secretary-Treasurer, George W. Macy, Columbus.

BENTON COUNTY MEDICAL SOCIETY
President, W. H. Altier, Fowler,
Secretary-Treasurer, L. P. Muller, Boswell.

BOONE COUNTY MEDICAL SOCIETY
President, Charles O. Weddle, Lebanon,
Vice-President, Lloyd M. Headley, Lebanon,
Secretary-Treasurer, Clarence G. Kern, Lebanon.

CARROLL COUNTY MEDICAL SOCIETY
President, James R. McLaughlin, Flora,
Secretary-Treasurer, Charles L. Wise, Camden.

CASS COUNTY MEDICAL SOCIETY
President, Russell Rollins, Royal Center,
Vice-President, Lowell J. Hillis, Logansport,
Secretary-Treasurer, Donald K. Winter, Logansport.

CLAY COUNTY MEDICAL SOCIETY
President, Timothy M. Weaver, Brazil,
Vice-President, Robert M. Maurer, Brazil,
Secretary-Treasurer, John M. Palm, Brazil.

DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
President, Emery B. Lett, Loogootee,
Vice-President, J. O. McCracken, Montgomery,
Secretary-Treasurer, A. G. Blazey, Washington.

DUBOIS COUNTY MEDICAL SOCIETY
President, George A. Held, Jasper,
Vice-President, Henry G. Backer, Ferdinand,
Secretary-Treasurer, Fielding P. Williams, Huntingburg.

ELKHART COUNTY MEDICAL SOCIETY
President, Raymond A. Fleetwood, Nappanee,
Vice-President, R. G. Horswell, Bristol,
Secretary-Treasurer, O. E. Wilson, Elkhart.

FLOYD COUNTY MEDICAL SOCIETY
President, Parvin M. Davis, New Albany;
Vice-President, Harry K. Engleman, Georgetown,
Secretary-Treasurer, John M. Paris, New Albany.

FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY
President, Irvin E. Booher, Connersville,
Vice-President, Perry F. Seal, Brookville,
Secretary-Treasurer, R. H. Elliott, Connersville.

FULTON COUNTY MEDICAL SOCIETY
President, Charles L. Herrick, Akron,
Secretary-Treasurer, Howard H. Rowe, Rochester.

GREENE COUNTY MEDICAL SOCIETY
President, William F. Craft, Linton,
Vice-President, Carl M. Porter, Jasonville,
Secretary-Treasurer, George E. Moses, Worthington.

GIBSON COUNTY MEDICAL SOCIETY
President, R. S. McElroy, Princeton,
Vice-President, James R. Montgomery, Owensville,
Secretary-Treasurer, Harry F. Carpentier, Princeton.

HAMILTON COUNTY MEDICAL SOCIETY
President, James W. Griffith, Sheridan,
Vice-President, J. C. Ambrose, Noblesville,
Secretary-Treasurer, Robert F. Harris, Noblesville.

HARRISON COUNTY MEDICAL SOCIETY
President, Edgar W. Murphy, Lanesville,
Vice-President, Guy D. Baker, Crandall,
Secretary-Treasurer, William E. Amy, Corydon.

HUNTINGTON COUNTY MEDICAL SOCIETY
President, James R. Ware, Huntington,
Vice-President, Howard H. Marks, Huntington,
Secretary-Treasurer, Grover M. Nie, Huntington.

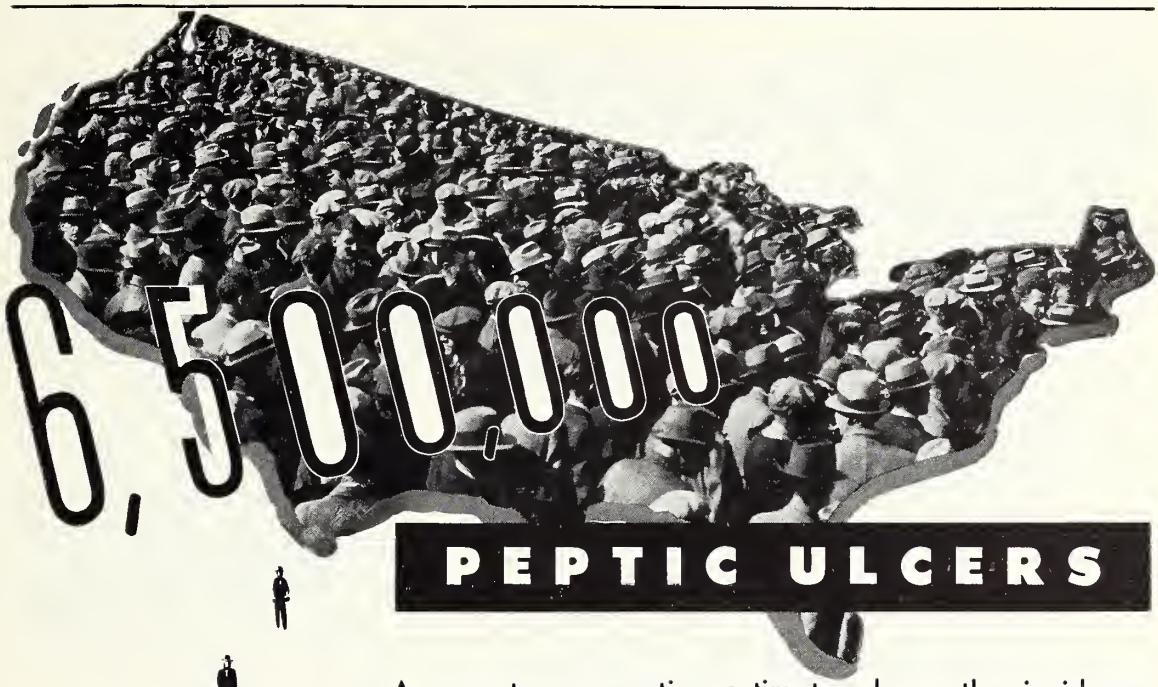
JACKSON COUNTY MEDICAL SOCIETY
President, W. H. Shortridge, Seymour,
Vice-President, Lawrence W. Elsner, Seymour,
Secretary-Treasurer, G. H. Kamman, Seymour.

JAY COUNTY MEDICAL SOCIETY
President, John M. Engle, Portland,
Vice-President, John Lansford, Redkey,
Secretary-Treasurer, H. Frederick Streib, Portland.

JOHNSON COUNTY MEDICAL SOCIETY
President, Russell C. Wilson, Franklin,
Secretary-Treasurer, Helen B. Barnes, Greenwood.

KNOX COUNTY MEDICAL SOCIETY
President, Maurice S. Fox, Vincennes,
Vice-President, Mordecai M. McDowell, Vincennes,
Secretary-Treasurer, Virgil C. McMahan, Vincennes.

LAPORTE COUNTY MEDICAL SOCIETY
President, R. W. Kepler, LaPorte,
Vice-President, C. N. Fischer, LaPorte,
Secretary-Treasurer, Daniel G. Bernoske, Michigian City.





A recent conservative estimate places the incidence of peptic ulcer at 5 per cent of the population, or about 6,500,000 persons in the United States.* The great majority of this vast group of patients need a year-in and year-out program of rest, diet and acid neutralization.

Creamalin, the first aluminum hydroxide gel, readily and safely produces sustained reduction in gastric acidity. With Creamalin there is no compensatory reaction by the gastric mucosa, no acid "rebound," and no risk of alkalosis. Through the formation of a protective coating and a mild astringent effect, nonabsorbable Creamalin soothes the irritated gastric mucosa. Thus it rapidly relieves gastric pain and heartburn, and helps in the healing of peptic ulcers as well as in the prevention of ulcer recurrence.

Winthrop CHEMICAL COMPANY, INC.
NEW YORK 13, N. Y. • WINDSOR, ONT.

Supplied in 8 fl. oz., 12 fl. oz. and 16 fl. oz. bottles.

CREAMALIN
Trademark Reg. U. S. Pat. Off. & Canada
The first brand of Aluminum hydroxide gel

* Bureau of Health Education, A.M.A. *Hygeia*, 24:352, May, 1946.

LAWRENCE COUNTY MEDICAL SOCIETY
President, Joseph C. Dusard, Bedford,
Vice-President, Charles B. Emery, Bedford,
Secretary-Treasurer, John P. Scherschel, Bedford.

MADISON COUNTY MEDICAL SOCIETY
President, Gordon B. Wilder, Anderson,
Vice-President, Benton M. Hensler, Anderson,
Secretary-Treasurer, Maynard A. Austin, Anderson.

MARSHALL COUNTY MEDICAL SOCIETY
President, Paul S. Connell, Plymouth,
Vice-President, H. H. Tallman, Culver,
Secretary-Treasurer, Louring W. Vore, Plymouth.

MONTGOMERY COUNTY MEDICAL SOCIETY
President, Fred N. Daugherty, Crawfordsville,
Vice-President, Maurice E. Gross, Ladoga,
Secretary-Treasurer, Wemple Dodds, Crawfordsville.

MORGAN COUNTY MEDICAL SOCIETY
President, Lawrence M. Hughes, Paragon,
Secretary-Treasurer, Robert W. VanBokkelen, Mooresville.

NOBLE COUNTY MEDICAL SOCIETY
President, Justin R. Nash, Albion,
Vice-President, Charles M. Bowman, Albion,
Secretary-Treasurer, Frank W. Messer, Kendallville.

ORANGE COUNTY MEDICAL SOCIETY
President, John K. Spears, Paoli,
Secretary-Treasurer, Clarence E. Boyd, West Baden.

OWEN-MONROE COUNTY MEDICAL SOCIETY
President, Dillon Geiger, Bloomington,
First Vice-President, Charles F. Pectol, Spencer,
Second Vice-President, George L. Mitchell, Smithville,
Secretary-Treasurer, Abraham M. Owen, Bloomington.

PORTER COUNTY MEDICAL SOCIETY
President, William C. Butman, Hebron,
Vice-President, Charles H. DeWitt, Valparaiso,
Secretary-Treasurer, John R. Frank, Valparaiso.

RANDOLPH COUNTY MEDICAL SOCIETY
President, Leo E. Jordan, Lynn,
Vice-President, L. B. Chambers, Union City,
Secretary-Treasurer, Paul W. Sparks, Winchester.

SHELBY COUNTY MEDICAL SOCIETY
President, Norman F. Richard, Shelbyville,
Vice-President, Rufus M. Nigh, Fairland,
Secretary-Treasurer, David B. Silbert, Shelbyville.

SWITZERLAND COUNTY MEDICAL SOCIETY
President, Jack King, Vevay,
Vice-President, George E. Ellerbrook, Vevay,
Secretary-Treasurer, Robert O. Zink, Vevay.

WARRICK COUNTY MEDICAL SOCIETY
President, Ralph E. Zwickel, Newburgh.
Vice-President, L. S. Taylor, Elberfeld,
Secretary-Treasurer, J. Guy Hoover, Boonville.

WAYNE-UNION COUNTY MEDICAL SOCIETY
President, James F. Lewis, Liberty,
Vice-President, C. Emil Kenyon, Cambridge City,
Secretary-Treasurer, Glen Ward Lee, Richmond.

WHITLEY COUNTY MEDICAL SOCIETY
President, V. Park Huffman, South Whitley,
Vice-President, Arthur Leiter, Columbia City,
Secretary-Treasurer, Claude J. Heritier, Columbia City.

Benton County Medical Society members held a meeting at the Country Club in Fowler, on December twenty-second. This was a dinner meeting, the eight members having their wives as guests. A business meeting was held following the dinner.

Boone County Medical Society members met at the Witham Hospital, in Lebanon, on December third. The guest speaker was Dr. N. P. Sullivan, of Indianapolis, whose subject was "Streptomycin." Election of officers for 1947 was held. Fourteen members were present.

* * *

Cass County Medical Society members held a meeting at the St. Joseph Hospital, in Logansport, on December twentieth. Officers were elected for 1947. Thirteen members were present.

* * *

Clinton County Medical Society members met at Clinton County Hospital, in Frankfort, on December third. The guest speakers were Dr. H. T. Stout, of Colfax, whose subject was "Undulant Fever," and Dr. S. B. Sims, of Frankfort, who discussed "The History of Medicine in Clinton County." Officers for 1947 were elected. Eighteen members attended the meeting.

* * *

Decatur County Medical Society members were guests of Dr. J. T. Morrison, of Greensburg, at a buffet dinner at his camp, on December eighteenth. Dr. Harvey W. Sigmond, of Indianapolis, gave an illustrated lecture, his subject being "Differential Diagnosis of Back Pain."

* * *

Delaware - Blackford County Medical Society members met at the Ball Memorial Hospital, in Muncie, on December seventeenth. A representative of the Medical Protective Society discussed malpractice insurance. Eighteen members attended the meeting.

* * *

Elkhart County Medical Society members met on December fifth at the Hotel Elkhart, in Elkhart. Dr. George E. Bowdoin, of Elkhart, gave a review of case histories of Cesarean sections in the Elkhart General Hospital. The annual election of officers for 1947 was held.

* * *

Fayette-Franklin County Medical Society members held a meeting at the McFarlan Hotel, in Connersville, on December tenth. In addition to the regular business meeting, election of officers for 1947 was held. The twelve members present also discussed the proposed addition to the present hospital.

The "One Prescription" Food for Bottle-fed Infants.....





- for full-term or premature infants
- from birth to end of bottle feeding
- complemental to mother's milk, or exclusively

POWDER

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Start with either ond change from one to the other, to suit individual requirements. Powder form is especially convenient when traveling.

Many physicians prescribe Baker's Modified Milk for the majority of their bottle-fed infant cases. They prefer Baker's Modified Milk because few cases require any change at any time, except increased quantity as the baby grows older.

Baker's Modified Milk is a time-saver for the doctor and for the mother, for it is a completely prepared food that requires no complicated feeding directions (just dilute with water, previously boiled) and therefore reduces the possibility of error.

Among the many other reasons for the wide prescription of Baker's Modified Milk are:

Baker's Modified Milk is a complete food (except for Vitamin C) that closely conforms to human milk in nutritional results . . .

. . . is well tolerated by both premature and full-term infants . . .

. . . may be used either complemental to or entirely in place of human milk . . .

. . . is helpful in correcting regurgitation, constipation, loose or too-frequent stools . . .

Just leave instructions at the hospital. The obstetrical supervisor will be glad to put your next bottle-fed infant on Baker's Modified Milk.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per quart.

Complete information and samples gladly sent to physicans on request.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC., CLEVELAND, OHIO BRANCH OFFICES: SAN FRANCISCO, LOS ANGELES and DENVER

Fort Wayne (Allen County) Medical Society members held their annual Christmas party in Fort Wayne, on December third. One hundred seventy-six members and guests were present.

On December seventeenth the members held their regular business meeting in the Chamber of Commerce Building, in Fort Wayne.

* * *

Floyd County Medical Society members met in New Albany, on December thirteenth. The guest speaker was Dr. Daniel C. Barrett, of Columbus, who talked on the relation of the State Board of Health to the local health unit. The election of officers for 1947 was held. Twenty-three members and two guests attended the meeting.

* * *

Gibson County Medical Society members were guests of the staff of the Gibson General Hospital, in Princeton, at a dinner on December ninth, when an election of officers for 1947 was held.

* * *

Greene County Medical Society members held a dinner meeting at the Freeman Greene County Hospital, in Linton, on December twelfth. An election of officers was held, in addition to the regular business meeting. Twenty members were in attendance.

* * *

Hancock County Medical Society members held a dinner meeting on December eleventh, at the Riley Hotel, in Greenfield. The guest speaker was Dr. Robert E. Kinneman, of Greenfield, whose subject was "Basic Principles of Electro-Cardiography." Officers for 1947 were elected.

* * *

Jay County Medical Society members met on December sixth at the Country Club, in Portland. Dr. W. D. Schwartz, of Portland, spoke on "Fifty Years of Medical Practice." Twenty-one members were present.

* * *

LaPorte County Medical Society members held a meeting at Wildwood Inn, in La Porte, on November twenty-first. The twenty-four members present heard a discussion of "Pre- and Post-Operative Treatment," by Dr. Daniel D. Stiver, of South Bend.

At a dinner meeting at Wildwood Inn, in La-Porte, on December nineteenth the annual election of officers for 1947 was held. Forty-one members and their wives were present.

* * *

Madison County Medical Society members held a dinner meeting at the Country Club, in Anderson, on December eighteenth. The speaker of the evening was Dr. Franklin B. Peck, of Indianapolis, whose subject was "Diabetic Problems." The meeting was attended by forty-five members.

Marshall County Medical Society members held a meeting on December fourth, in Plymouth. Dr. James S. P. Beck, of Fort Wayne, presented pictures of flash burns at Nagasaki. Eighteen members were in attendance at this meeting.

* * *

Montgomery County Medical Society members met on December nineteenth for a dinner meeting at the Culver Hospital, in Crawfordsville. Dr. James F. Balch, of Indianapolis, spoke on "Tuberculosis of the Urinary Tract." His talk was illustrated by a group of lantern slides. Twenty-seven members and two guests attended the meeting.

* * *

Morgan County Medical Society members met at the Memorial Hospital, in Martinsville, on December eighteenth. A presentation of cases was given by various members. Officers for 1947 were elected. Six members were present.

* * *

Noble County Medical Society members attended a luncheon in Kendallville, on December seventeenth. In addition to the regular business meeting, the officers for 1947 were elected. Eighteen members were in attendance at this meeting.

* * *

Owen-Monroe County Medical Society members held a meeting at the Graham Hotel, in Bloomington, on November twenty-ninth. The guest speaker of the evening was Dr. Cleon A. Nafe, of Indianapolis, whose subject was "A Report of One Hundred Twenty-nine Cases of Hypertrophic Pyloric Stenosis." An election of officers was held. Twenty-five members were present.

* * *

Parke-Vermillion County Medical Society members met on December eighteenth, at the Vermillion County Hospital, in Clinton, when an election of officers for 1947 was held. Fourteen members were present.

* * *

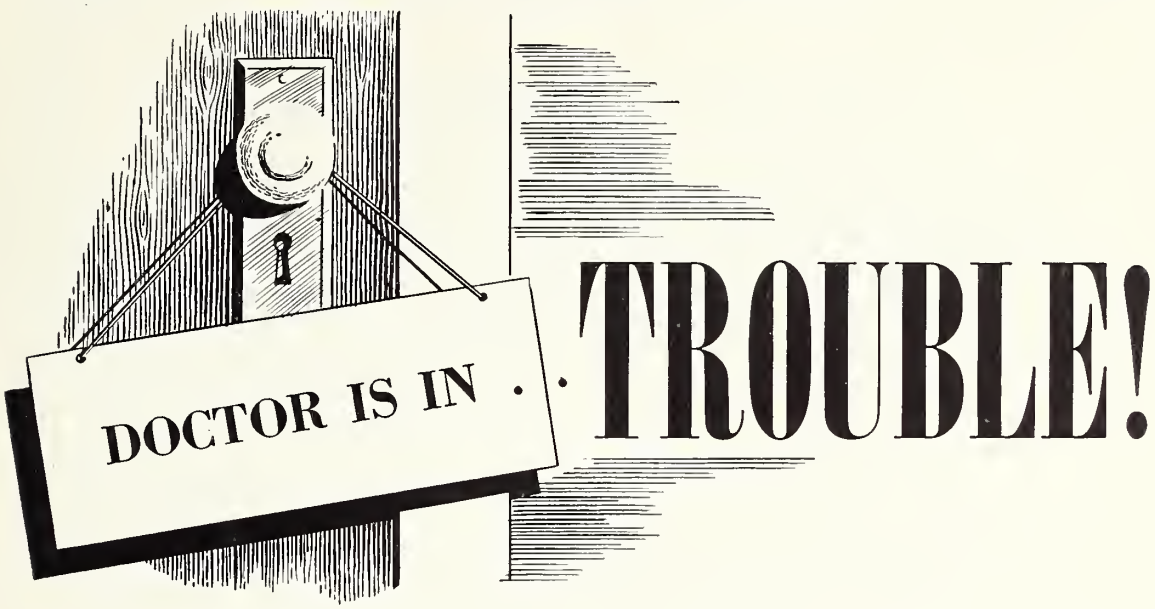
Randolph County Medical Society members met on November eighteenth, in Winchester. Dr. Fred McK. Ruby, of Union City, discussed "Ear, Nose, and Throat Office Practice for the General Practitioner." His talk was illustrated with slides. Twelve members attended the meeting.

* * *

Switzerland County Medical Society members held a meeting on December thirteenth, in Vevay. Officers for 1947 were elected. Six members were present.

* * *

Warrick County Medical Society members met on December twelfth, in Elberfeld. The speaker for the evening was Dr. Elvin L. Fitzsimmons, of Evansville, whose subject was "Ambulatory Treatment of Proctological Conditions." The annual election of officers for 1947 was held. Seven members attended the meeting.



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SEVENTH COUNCILOR DISTRICT

Dr. Harry Murphy, of Franklin, was chosen as president-elect of the Seventh Councilor District at its winter meeting, held December 10 in the First Christian Church in Danville. Doctor Murphy will take office January 1, 1948. Dr. Horace M. Banks, of Indianapolis, the incumbent, was re-elected as secretary-treasurer. A scientific meeting was held in the afternoon with these subjects: "Cirrhosis of the Liver," by Drs. Rollin H. Moser, Bernard Rosenak and Byron Kilgore, Jr.; "Low Back Pain," by Drs. George J. Garceau and Fred Brown.

At the evening meeting the chief address was given by Mr. Wayne Guthrie, city editor of the Indianapolis News, who witnessed the A-Bomb explosion last summer at Bikini atoll in the Pacific. Mr. Guthrie, who was introduced by Dr. E. Vernon Hahn, described the blast and told of the destruction which it caused. The meeting was presided over by Dr. O. T. Scamahorn, of Pittsboro, retiring president of the district.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Recording Secretary—Mrs. J. L. Allen, Greenfield.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. O. H. Bakemeier, Indianapolis.

Mrs. S. J. Petronella, our state president, gave the following talk at the Conference of County Medical Society Secretaries on January twelfth, in the Claypool Hotel, Indianapolis:

"Auxiliary Membership Plans

"The most outstanding honor and accomplishment in my career as president of the Woman's Auxiliary to the Indiana State Medical Association is being present today at this meeting. It long has been the hope of the Auxiliary to be fully recognized, and to speak to you today fulfills one of our greatest ambitions.

"The general scope of our existence is best expressed in the Auxiliary Collect, which reads:

" 'We ask Thee, O God of Heaven and Earth, to keep us, we the helpmates of those whose life work is the ministry of healing.

" 'May we learn to know that their sacrifice is not small, but motivates their lives in service to others. Help us to have unselfish, understanding hearts.

" 'Keep us patient and forebearing, and as it is given to us to keep the hearth of our home fires swept clean of pettiness, so give us strength to be kind and generous in thought at all times.'

"Our projects are many and varied. The Auxiliary has played a great role in public relations, especially in regard to political medicine. Every member receives approved literature in regard to medical legislation so that she will be well informed when dealing with the dissemination of accurate knowledge concerning the harmful effects of present social and economic movements on the practice of medicine today. We have endeavored to help in health education through different types of programs and radio broadcasts for the public—all approved by our advisory committee. Throughout the state, we have assisted and promoted projects to combat juvenile delinquency. We have, in our constituent auxiliaries, worked in almost every phase of Red Cross work. We have already made a great contribution to the 'Sample Drug Collection' sponsored by the American Medical Association. Our philanthropic undertakings have been of so many types that time does not permit enumerating them, but most outstanding are nurse scholarships and material donations to service men's hospitals. We have done our share in the promotion and selling of *Hygeia*.

"At a recent President's Conference of the Auxiliary to the American Medical Association, I was astounded to learn, in figures especially, how much moral and financial help other state auxiliaries receive from their medical societies. Nearly all state auxiliaries are completely financed by their medical societies and it is rare when almost complete eligible membership is not reported.

"The only requirements are that the applicant be the wife of a doctor who is in good standing in his respective medical society. This makes us very exclusive! On our own, we have organized about one-third of the doctor's wives in Indiana, and to prove that the Auxiliary has interested and enthusiastic members I wish to remind you that our registration at the last medical convention was greater than that of the doctors.

"Our greatest project this year is organization and this is where we need your help. We want every county and every district in Indiana to be represented in the Auxiliary. If in every county where there is no auxiliary the president and secretary of the local society of such counties would submit the names of their wives for membership in the Auxiliary, they could be our representatives. In some councilor districts doctors' wives have enjoyed and benefited by having joint meetings. Our state dues amount to the colossal sum of seventy-five cents and national dues are one dollar. Our total membership is one thousand nineteen women, and we have twenty-four organized counties.

"At the American Medical Association Convention, to be held in Atlantic City this year, a large map of Indiana will be displayed along with those of the other states, and the unorganized districts will be filled in black. With your help and cooperation I hope our map will have no blacked-

Special Notice to Members

The Continental of Chicago has approved for enrollment, members of your State Medical Society, eligible for "Professional Group" Disability plus Life Income for Total Permanent Disability. Protection is provided thruout Life and does not terminate at age 60, leaving you without protection when your income is at its peak. It pays from first day so long as you are disabled and in event of total permanent disability, pays as long as you live. The regular monthly benefits are $400 per month and double indemnity $600. Hospitalized disability pays as high as $1,000 a month and $1,200 for double indemnity.

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NON CANCELLABLE—The Company's right to cancel any individual member's policy or to refuse its renewal so long as the member is actively engaged in his profession and the group is in effect is eliminated. Standard Provision No. 16 is not in the contract.

NON AGGREGATE—The Company's right to limit their liability under a claim, because of previous claims paid is eliminated. Standard Provision No. 19 is not in the contract.

NON ASSESSABLE—The Company's right to assess additional premiums is eliminated. No Contingent Liability Clause, all premium rates guaranteed.

When any one, or more, of the above restrictive clauses are present in your Health or Accident policy, there can be no *certainty* the stated benefits will be paid you and there is no permanence to your disability protection.

It is the practice of the Continental to submit their Income Replacement Plan to the individual members of the group for their personal consideration, because it brings about a decidedly better understanding of the Plan and thereby increases the ultimate enrollment. Our enrollment is proceeding most satisfactorily and is conducted with full consideration for the policy and practice of the Society and its Councellors.

Should any Registrar, or Salesman represent that he is from the Society or that this plan has been endorsed by the Society, kindly report same together with the name of the representative to Boyd and Boyd, Managers, Professional Group Department, 11th floor, 30 East Adams Street, Chicago 3, Illinois—Telephone, State 2986.

Your co-operation in reporting such will be much appreciated.



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out areas. Let us be proud of our State of Indiana!

"I want to thank you again for the privilege of talking to you and on behalf of the Auxiliary, I am very grateful for this recognition."

Elkhart County

The Woman's Auxiliary had a dinner meeting in the Y.W.C.A., in Elkhart, followed by a Christmas party in the home of Mrs. Arthur Hull, on December fifth.

Hancock County

Mrs. J. E. Ferrell entertained the Woman's Auxiliary to the Hancock County Medical Society at her home in Fortville, on December tenth. Mrs. Charles Gibbs, of Greenfield, the president, presided during the business meeting. Officers elected for the ensuing year are: Mrs. D. D. Gill, of Greenfield, president; Mrs. J. E. Ferrell, secretary and treasurer. Mrs. M. B. Ferrell is president for 1947.

Lake County

The president, Mrs. David Eisenberg, called a special meeting of the Hammond branch of the Woman's Auxiliary to the Lake County Medical Auxiliary on December tenth, which was held in her home.

Marion County

The Auxiliary members were guests of their husbands on January eleventh, at the annual dinner-dance and installation of officers in the Indianapolis Athletic Club. Among special out-of-town guests, with their husbands, were: Mrs. Don F. Cameron, of Fort Wayne, Mrs. Alfred H. Ellison, of South Bend, and Mrs. F. S. Crockett, of Lafayette.

St. Joseph County

The Woman's Auxiliary opened its fall program on October eighteenth with a tea. Mrs. Keith Selby, the president, presided. Forty members and guests attended.

The second meeting was a dessert luncheon, on November fifteenth, followed by a short business meeting. A ten dollar Tuberculosis Bond was purchased. Mr. Ray E. Smith, executive secretary of the Indiana State Medical Association, was guest speaker. His talk was on "Medical Insurance in Indiana."

The project for 1946-1947 is to promote the sale of *Hygeia*. St. Joseph County Auxiliary made a record for itself in 1945-1946 in placing Hygeia in the county schools and many reading rooms and beauty shops. They hope to surpass their record this year.

Vigo County

The Vigo County Auxiliary held its annual dinner meeting in January, followed by a book review by Mrs. E. L. Mattox.



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For One Year (terms expire Dec. 31, 1947): Don F. Cameron, M.D., Fort Wayne, and F. S. Crockett, M.D., Lafayette. Alternates: Norman M. Beatty, M.D., Indianapolis, and A. M. Mitchell, M.D., Terre Haute.

For Two Years (terms expire Dec. 31, 1948): H. G. Hamer, M.D., Indianapolis, and A. S. Giordano, M.D., South Bend. Alternates: Karl R. Ruddell, M.D., Indianapolis, and George Collett, M.D., Crawfordsville.

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District	*Councilor*	*Term Expires*
1	I. C. Barclay, Evansville	Dec. 31, 1947
2	James H. Crowder, Sullivan	Acting
3	A. P. Hauss, New Albany	Dec. 31, 1949
4	Charles F. Overpeck, Greensburg	Dec. 31, 1947
5	A. M. Mitchell, Terre Haute	Dec. 31, 1948
6	W. U. Kennedy, New Castle	Dec. 31, 1949
7	Cyrus J. Clark, Indianapolis	Dec. 31, 1947
8	E. H. Clauser, Muncie	Dec. 31, 1948
9	Wemple Dodds, Crawfordsville	Dec. 31, 1949
10	William H. Howard, Hammond	Dec. 31, 1947
11	C. S. Black, Warren	Dec. 31, 1948
12	Paul A. Garber, South Whitley	Dec. 31, 1949
13	Alfred Ellison (Chairman), South Bend	Dec. 31, 1947

OFFICERS OF COUNCILOR DISTRICTS—1947

District	*President*	*Secretary*	*Place and date of meeting*
1	William M. Cockrum, M.D., Evansville	Virgil McCarty, M.D., Princeton	
2	K. L. Hull, M.D., Bloomfield	J. S. Brown, M.D., Carlisle	
3	Percy R. Pierson, M.D., New Albany	William F. Edwards, M.D., New Albany	New Albany, June 4
4	L. H. Osterman, M.D., Seymour	H. P. Graessle, M.D., Seymour	Seymour, May 14
5	Richard S. Bloomer, M.D., Rockville	M. C. Topping, M.D., Terre Haute	Terre Haute, May 2
6	Will A. Thompson, M.D., Liberty	R. W. Kuhn, M.D., Wilkinson	Richmond, May 8
7	Leon Gray, M.D., Martinsville	Horace M. Banks, M.D., Indianapolis	Martinsville
8	Forrest E. Keeling, M.D., Portland	Homer F. Streib, M.D., Portland	Portland
9	Lee J. Mavis, Attica	J. E. Fisher, Attica	Attica, May 15
10	George M. Cook, M.D., Hammond	A. C. Remich, M.D., Hammond	Schererville, Apr. 10
11	Max R. Adams, M.D., Flora	O. G. Brubaker, M.D., North Manchester	Huntington, May 21
12	Richard L. Hane, M.D., Fort Wayne	G. T. Bowers, M.D., Fort Wayne	Fort Wayne, May 6
13	Ernest L. Dietl, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 12

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Photographs should be printed on glossy paper. Negatives are not acceptable.

Only a limited number of illustrations can be used with each original article. If an excessive number are submitted for publication, the cost of extra illustrations must be borne by the author.

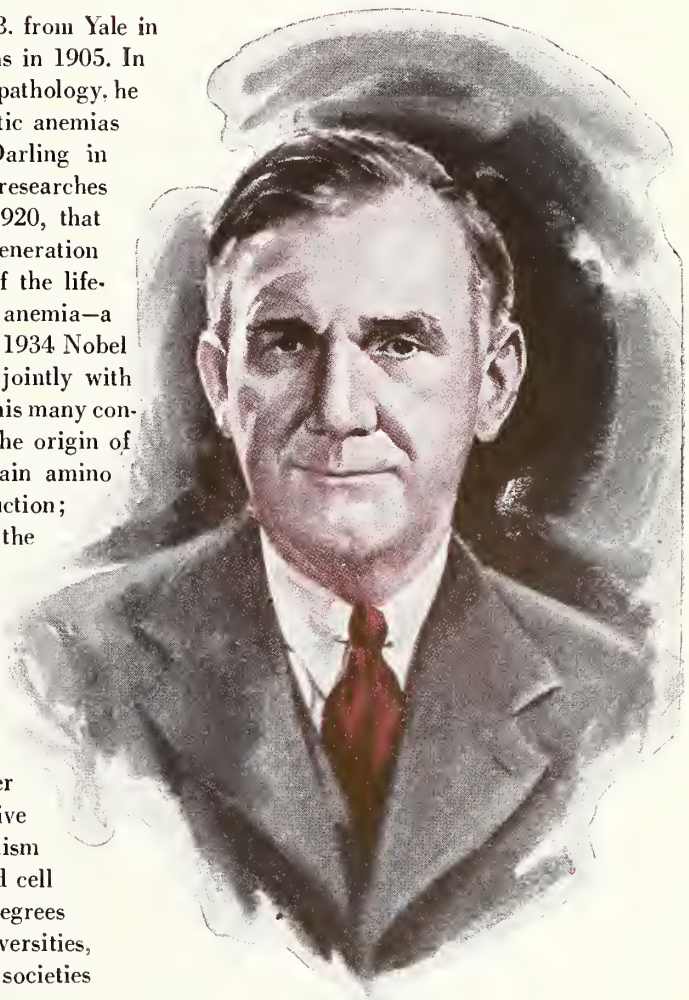
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Men and Amino Acids

George H. Whipple received his A.B. from Yale in 1900, and M.D. from Johns Hopkins in 1905. In pursuing his bent for investigational pathology, he studied blackwater fever and parasitic anemias under General Gorgas and Dr. Darling in Panama. In 1917, he began extended researches on anemias. The observation, in 1920, that liver was beneficial in blood regeneration paved the way for the revelation of the life-saving value of liver in pernicious anemia—a discovery for which he received the 1934 Nobel Prize in Physiology and Medicine jointly with Doctors Minot and Murphy. Among his many contributions were those dealing with the origin of plasma proteins; the value of certain amino acids in increasing hemoglobin production; the potency of dietary factors in the formation of hemoglobin and plasma proteins; studies on reserve stores of protein-building materials; and the dynamic exchange of protein materials within the body.

Dr. Whipple is recognized as a pioneer in the experimental use of radioactive isotopes in the study of the metabolism of hemoglobin, plasma proteins, and cell proteins. He has received honorary degrees from many American and foreign universities, and numerous honors from scientific societies here and abroad.



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TEN THOUSAND SPINAL ANESTHESIAS; FIVE THOUSAND WITH EPHEDRINE INTRATHECALLY — RANDOM COMMENT*

FLOYD T. ROMBERGER, M.D.

FRANK W. RATCLIFF, M.D.

LAFAYETTE

THE purpose of this presentation is to place on record the completion of a series of ten thousand spinal anesthesias, pertinent data concerning which was individually recorded and card-indexed in a separate, personal file for reference and study. All these anesthesias were administered in the same community, in the same hospitals, and for relatively the same group of surgeons over the years.

The first of these spinals was given on November 5, 1928, to a patient seventy-nine years of age, for the suprapubic enucleation of his prostate. The ten thousandth spinal was given on August 12, 1946, for a cesarian operation upon a physician's wife. This spread of almost eighteen years is of interest, because it covers a sufficient length of time to bring the methods used through their developmental phases, so that thorough clinical study and evaluation could be made and their proved worth weighed and balanced. The first five thousand records were accumulated over a period of fourteen years and one month, an average of 29.5 per month, or one per day; the second, in three years and eight months, an average of 113.6 per month, or about four per day. Some days, of course, there were none, and the highest single-day total was thirteen. All this bespeaks a growing demand among surgeons and the laity for this type of anesthesia, and it demonstrates how from a slow and cautious beginning the several techniques evolved into major acceptance in the practice of anesthesiology.

* Presented before the Section on Anesthesia of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

The Early Years

Eighteen to twenty years ago the contemporary literature upon the technique of spinal anesthesia, as we now understand it, for major abdominal surgery, was scarce indeed. Information in the texts of that day was scanty and often misleading. There were relatively few or almost no clinics where the method could be observed and studied.

The early difficulties encountered, therefore, were not those of a proper spinal puncture, but rather those of inability to predict height and duration and safety with any degree of reasonability. Causes for these factors were sought and found in an intense study of the anatomy of the spine and of the nerve roots of the cord, and also in a thorough exploration of the principles of turbulence, gravitation, and capillarity, often unscientifically classified as diffusion.[1]

It soon became evident that, contrary to widespread opinion in those early years, with the use of ephedrine, subcutaneously, it was not always necessary, nor always good anesthetic and good surgical judgment, immediately to place every patient in the marked Trendelenburg position following injection. This, coupled with the fact that novocain dissolved in the patient's own spinal fluid gives a solution slightly heavier than the spinal fluid itself, lead to an approach toward greater controllability and increased duration by injecting larger and still larger doses of novocain dissolved

1. Romberger, Floyd T.: Spinal Anesthesia, Practical Facts and Common Fallacies—Clinical Research on Prolonged Spinal Anesthesia, Using Vasoconstrictor Adjunctives, Anesth. and Analg. **22**:252-263 (Sept.-Oct.) 1943.

in smaller and smaller bulks of spinal fluid, and allowing the spine to be flat or level until the anesthesia became fixed at the desired height, then slightly elevating the upper thoracic and cervical canal to prevent further upward extension. In the meantime accurate records were kept for study. The results were quite satisfactory, inasmuch as better than an hour of anesthesia could be promised for abdominal surgery, employing novocain alone.

Drugs Used

Practically every known and reasonably applicable anesthetizing agent was given clinical trial in this series: novocain, spinocaine, gravocain, metycaine, pontocaine with and without glucose, and nupercaine. No prejudice exists nor is any criticism intended of or for or against any drug or technique whatsoever, just so good results are obtained. However, a comprehensive study of these ten thousand records proves beyond any shadow of a doubt that, at least until now, practically every surgical condition wherein this type of anesthesia is indicated can be met adequately with two anesthetizing agents, novocain for operations lasting one hour to an hour and twenty minutes or less, and novocain combined with nupercaine for surgery extending beyond three hours. In the final analysis these were the drugs employed in the vast majority of cases in this series. This was done largely to avoid a multiplicity of agents and techniques and to hold strictly to the utmost degree of simplicity in administration.

Prolongation With Nupercaine

Simply by adding relatively small amounts of 1-200 nupercaine solution to the novocain-spinal fluid mixture to be injected will give adequate prolongation. This method first was given clinical trial in 1930, and the results and technique thereof first were published in 1931, and subsequently.[2, 3] This method continues to prove very satisfactory for long surgery, and in this series it was employed 2,118 times.

Vasomotor Constrictor Prolongation

In 1935, after considerable theorization, minim doses of 1-1,000 adrenalin were added to the intrathecal injection for the purpose of prolonging the novocain anesthesia in a few selected cases. Although considerable prolongation resulted, the onset usually was so slow that the method was abandoned temporarily. It now is thought that the initially-ensuing intense ischemia was the delaying factor, at least it gave that clinical picture then, and, when the technique again was tried in 1942,[1] with total intrathecal injection dilutions of epinephrine, from 1-60,000 to 1-180,000, the results were better.

During this latter period the use of ephedrine intrathecally was conceived because ephedrine is a mild vasoconstrictor when applied locally. The results have been most advantageous, in that measurably prolonged anesthesia is produced with considerable less dosage of novocain. The method first was used on September 10, 1942; a preliminary report on the technique was made in 1943;[1] and upon the completion of this series of ten thousand spinal anesthesias it had been employed in 5,235 consecutive cases.

These patients look better on the table and are better. They have an improved color, pinker than normal; their pulse and blood pressure is more adequately sustained, normal or even better than normal; oxygen for anoxia was administered less than one-tenth as frequently; and prolongation of the anesthesia with given dosages of novocain approximates fifty per cent. The clinical picture of patients anesthetized by this method was so greatly improved that further intensive study lead to the clinical conclusion that in addition to the prolongation of the anesthesia two other measurably beneficial effects were being obtained, namely: First, a vasopressor drug was being introduced intrathecally which, slowly absorbed, aided materially in sustaining the blood pressure and the circulation to the vital centers. Secondly, according to the report of Shultz,[4] ephedrine hydrochloride is locally anesthetic to nerve roots and trunks, and is reversibly so. He stated that 0.1 per cent ephedrine hydrochloride produces anesthesia in the human when injected subcutaneously, and for spinal anesthesia in a frog the minimal anesthetic dose is 0.1 mgm./gm.

This anesthesia, first tried in this series in 1935, then adopted routinely on September 10, 1942, and administered 5,235 times since then, leads to the rather strong conviction that this innovation of adding a vasoconstrictor drug to the intrathecal injection marks a notable improvement in the technique, and the method is recommended to others.

Case Reports

Practically every surgical condition found between the clavicle and the toes was encountered in this series, but a more detailed case analysis must await further studies and future presentations. Suffice it to report at this time that 690 of the operations were performed on the gall bladder and its ducts; 138 were on the stomach, including perforated gastric ulcers, gastric resections, and gastroenterostomies; and 450 were cesarians. There were two radical breast amputations with axillary dissection, two thoracoplasties, and two laminectomies with bone transplants. The latter three types of cases were handled in this manner, anesthetically, largely to evaluate the possibilities, and

2. Romberger, Floyd T.: Novocain-Nupercaine Spinal Anesthesia, New Series, Am. J. Surg. 9:471-477 (March) 1931.

3. Ratcliff, Frank W.: Nupercaine Combinations Used in Spinal Anesthesia. J. Ind. State Med. Assn., 32:74-77 (Feb.) 1939.

4. Shultz, Fred H.: The Local Anesthetic Properties of Ephedrine Hydrochloride, Anesth. 1:69-71 (July) 1940.

spinal anesthesia for such surgery is not recommended as a routine procedure.

Complications

There were no operating room fatalities in this series attributable to the anesthesia per se. Nor were there any notable neurological postoperative complications reported by the attending surgeons. There were, of course, rumors and complaints and gossip, but upon thorough investigation all proved to be explainable as being due to other causative factors.

Common Fallacies

Even a very casual dipping into this file of records proves the fallacy of many heretofore commonly-accepted and published slide-rule formulae for administering spinal anesthesia. Among these, a few are briefed:

(1) Such and such a dosage in milligrams for such and such weight of the patient.

(2) A definite dosage in milligrams for the various surgical procedures.

(3) That a certain dosage in milligrams is safe, and that another dosage is unsafe.

(4) That a certain per cent solution is the optimum per cent.

(5) That so many cc. should be used for a certain height of anesthesia upon the body surface.

All of these postulates are more or less illusional, in that they are apt to entice the novice in anesthesiology to believe that mathematical exactness in the resulting anesthesia can be obtained merely by memorizing a few rules of thumb. Nothing could be more misleading nor more disappointing. These misconceptions have been discussed in detail in a previous thesis.[1]

Summary

Brief comment has been made upon a completed series of ten thousand spinal anesthesias. Constant study of and frequent reference to these detailed records is a veritable mine of information on technique. Thorough understanding of the principles involved, plus reasonable alertness in recognizing clinical phenomena, enables one to finesse each surgical problem as regards height, intensity, and duration of the resulting anesthesia.

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CARE OF INTERTROCHANTERIC FRACTURES OF FEMUR

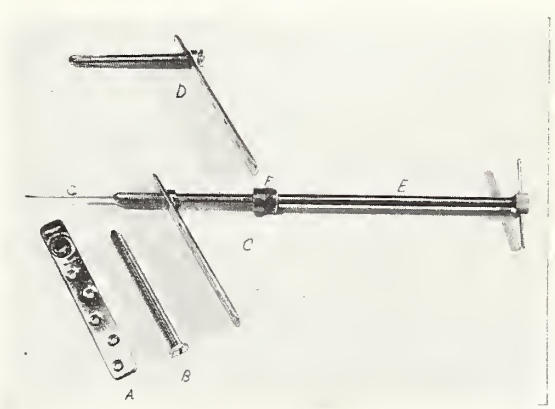
F. E. HAGIE, M. D.

RICHMOND

IN the care of hip fractures we have the two classes, the intracapsular or neck fractures of the femur, and the extracapsular or intertrochanteric fracture of the femur. In the care of the intracapsular or neck fractures of the femur, I have used my lag screw spear pins since 1938. The technic was published in THE JOURNAL of the *Indiana State Medical Association* of July, 1939. This method has met with very good results and I have been more than pleased in the series taken care of by this procedure.

In this article I wish to describe and illustrate the method I am using in the care of the extracapsular or intertrochanteric fractures of the femur by the open method. The internal fixation is by plate A and lag screw B as shown in Figure I. The plate A, made of stainless steel, four and one quarter inches long and three quarters of an inch wide, has a threaded shoulder set at a 127 degree angle. The lag screw B, made of stainless steel, is three-eighths of an inch in diameter and three and one-half inches long with a canal in the center. The lag screw has a dyed end for lagging into the neck and head of the femur. In C of Figure I is shown the assemblage during the introduction, consisting of a Kirschner wire G as guide, plate and lag screw with the wrench E and the adapter F. The wrench E is the same as I use to tighten the nuts on my neck pins and I have made an adapter F for the connection with this larger lag screw head. The plate and screw anchored together is shown in D of Figure I.

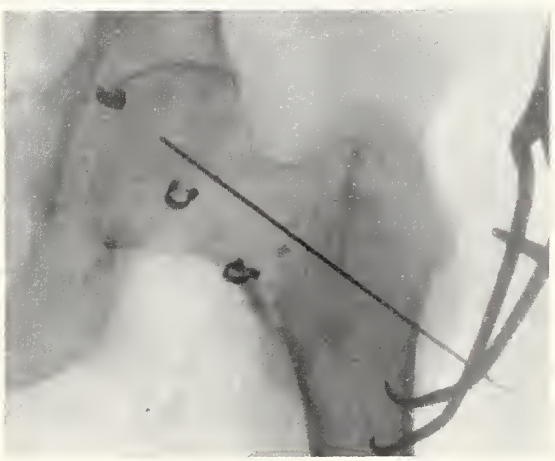
Figure I



The introduction of the plate and lag screw rests entirely on the accuracy of the placing of the Kirschner wire. With the wire properly placed the plate is first attached to the side of the femur according to the inserted wire and then the lag screw is attached through the plate up the wire into the neck and head of the femur. This point alone makes the plate and lag screw easily and accurately inserted.

With the fracture reduced and held in position, the x-ray is taken to see if the reduction is satisfactory. At the time of taking this x-ray my marked T is placed over the anterior part of the hip area, to give the surface markings of the top of the head of the femur and the center of the neck line. The area is then opened on the side of the femur and a Kirschner wire is inserted, following the surface markings as shown in Figure II.

Figure II



The outer layer of the femur around the wire is drilled to the size of the lag screw. With the lag screw just started through the plate, the two are placed through the wire with the plate against the surface of the femur. The plate is then attached to the femur, usually with three screws, so that the plate is solid to the femur before the lag screw is screwed into the neck and head. The lag screw, with the plate fixed to the femur, is screwed through the shoulder of the plate and into the neck and head as shown in Figure III. Figure IV is a lateral view of the same case. The guide wire has been removed and the fixation is complete.

Figure III



Figure IV



From a mechanical point of view, the procedure is very easy to apply this fixation to this type of fracture. For this reason I think this shoulder plate and lag screw combination justifies consideration by surgeons caring for these injuries.

THREE PHYSICIANS REPORT ALLERGIC REACTIONS TO PENICILLIN

There are at least three reported types of allergic reactions to penicillin, according to three doctors writing in the current issue of the Archives of Dermatology and Syphilology, published by the American Medical Association.

The physicians—Sidney Friedlaender, of Detroit, and Robert M. Watrous and Samuel M. Feinberg, of Chicago—state that the most common allergic response is hives. "In most instances this resembles a serum sickness type of reaction and does not interfere with the continuation of treatment," they state.

Another type of reaction is an eruption of blisters following penicillin treatment. This reaction appears to be related in some manner to a previous fungous infection of the skin. Contact dermatitis, which is almost always a local reaction, is a third manifestation.

The doctors report five cases of contact dermatitis in persons handling penicillin. They state that "all of the patients were completely relieved of symptoms when removed from contact with the drug. Four of these patients were industrial workers engaged in the manufacture of penicillin for commercial use, and one was a chemist producing the drug by the surface culture method for experimental study."

The physicians point out that the "patients in this study as well as the majority of those described in the literature have been persons engaged in the manufacture or handling of penicillin, rather than patients under treatment with the drug. This is readily understood when it is recalled that until recently penicillin was employed chiefly by the parenteral route. No prolonged and repeated contact with the skin or mucous membrane had occurred in the vast majority of patients treated. In our present series we noted that a relatively long period of contact with the allergen (nine to eighteen months) was necessary before sensitization became manifest. It is also conceivable that the skins of persons handling chemicals possess a lower tolerance to allergenic agents than the skin of the average person."

In conclusion, the authors say that the "rapidly increasing use of penicillin locally in such forms as ointments, sprays, drops, troches and lozenges will create many opportunities favoring the development of the contact type of allergic reaction."

SURVEY OF THE TREATMENT OF SYPHILIS*

JOHN ERIC DALTON, M.D.

INDIANAPOLIS

IN looking back over the centuries at the efforts made to establish better plans for the treatment of syphilis one finds that such endeavors have always cycled with periods of high enthusiasm followed by other periods of smug complacency.

Probably the darkest period of this whole history was in those four hundred-odd years between the end of the fifteenth and the beginning of the twentieth centuries. Throughout that long era the sole therapy hinged chiefly upon various types and methods of administering the mercurials. It might be added that there was no real scientific reason for their beginning the use of mercury in this disease, other than the fact that it was employed in many other and varied diseases existent at that time. Thus when syphilis made its appearance in virtually epidemic proportions in Europe following the Siege of Naples, they reached for this drug, and more or less accidently selected one which did have some degree of merit. As we know, much of the treatment of that early period was carried on by traveling quacks, because physicians looked somewhat askance upon the treating of those so infected.

Towards the end of the nineteenth century there even grew up an attitude of therapeutic nihilism with regard to the treatment of early cases. At that time some physicians of learning and prestige proposed that individuals in early syphilis should not be treated at all. They deduced that mercury was a relatively inefficient drug and thus contended that rather than use it, one should leave these patients alone, to build their own immunity against their disease. In their opinion each individual had an immune building power within himself to combat disease and that it was wrong to upset the equilibrium of that process by substituting a drug which in itself was rather ineffectual towards curing. We know now such logic was false but it did provide a known pool of diagnosed but untreated early cases which later made possible a most interesting study. Lomholt, who as a young man had been associated with one of the clinics in which those ideas prevailed, undertook the task—several years later—of checking back on a sizeable number of those cases who had passed through that clinic in that period. He examined these people by a careful physical checkup and the blood and spinal fluid tests which were available then. He found that roughly 25 per cent of those patients showed no evidence of the disease in the physical findings or blood or spinal fluid tests. Another 25 per cent, though they had positive blood serologies, were without signs in the physical or spinal checks. In other words, 50 per cent of these people—after a number of years—were to all appearances cured or living in a healthy balance in regard to their earlier disease. In the other 50 per cent there was considerable tragedy of late complications. Though such views are not now tenable—since we know far higher percentages of cure are obtainable with treatment—it did demonstrate to us that syphilis is not always the highly destructive disease which we are sometimes prone to believe it to be.

A little later came the work of Ehrlich and his discovery of arsphenamine. Enthusiasm boomed and it was suggested that one treatment of this new wonder drug would cure. It was not long before medicine had to back-track from that view. Then the same worker gave us a second arsenical preparation—neoarsphenamine. Then discussions arose among different groups as to the ways in which these drugs should be employed. Some went over to the use of arsenicals alone. Others chose to use arsenicals in series, running concurrently or alternating with series of mercurial injections. Some chose to use courses consisting of alternating series of the two drugs and with vacations interspersed (alternating intermittent type) while others chose to use alternating series of the two drugs but with series following directly on each other (alternating continuous type). Even toward the end of this time some workers proposed a quick intensive plan of that day in which the two drugs were carried concurrently (intensive type). In the midst of all this Levaditii introduced Bi in 1922 into the treatment of syphilis. Confusion arose again as to whether to go to the sole use of the Bismuth salts, or whether to remain with the arsenical-mercurial plans, or whether to retain the arsenical series and substitute Bi salts in the place occupied by the mercurials.

When all of this controversy reached a high boiling point the then new League of Nations, through their Council on Health, proposed that an unbiased study be conducted. They selected certain clinics in various countries where good records had been kept over a period of years, and proposed that by careful analytical studies of these files to try to arrive at some definite conclusions regarding both clinical and therapeutic angles of this disease. For this they selected certain clinics in England, France, Germany, Sweden and the United States, and thousands of records were combed in this study, which took several years for its completion. With regard to the question of

* Presented before the Indianapolis (Marion County) Medical Society, at Indianapolis, on March 26, 1946.

therapy they studied (1) those who had received no treatment at all, (2) those who had been treated by an intermittent plan, (3) those who had been treated by the continuous alternating plan, and (4) those who had been treated by the intensive plans of that period. Their report demonstrated beyond all doubt that the largest percentages of cure in early syphilis occurred where the continuous alternating plan was used. No other plan even approached the number curable with this regimen. Further they found that the earlier in the disease that the treatment was instituted, the higher was the chance of cure. In early disease they recommended that treatment consist of forty arsenical and forty bismuth salt injections given over a period of seventy-four weeks. Any departure from regularity—either in respect to the patients' lapsing from treatment or the physicians' departure from the schedule—showed a marked lowering in the patients' chance of cure. Under the optimal conditions the following percentages of cure were roughly demonstrable by this plan:

(1) Seronegative, darkfield positive	95 per cent.
(2) Seropositive primary	85-90 per cent.
(3) Secondary	80-85 per cent.

This plan certainly gives as high a percentage of cure rate as any plan used to date or now proposed, but it does have the disadvantage of being a rather arduous schedule, extending over a rather long period, which they must adhere to religiously if the optimal result is to be secured. Thus in this plan the most important visit is that of the first day when the physician must take sufficient time to sit down and lay before the patient the whole problem of his disease and its treatment. This fulfilled, and if the patient has average intelligence, one usually secures good cooperation and regularity of treatment on his part.

Now we have arrived in a new period literally bulging with new ideas on the treatment of syphilis. It is well for us to keep in mind, as we approach these new plans, that the evaluation of any form of antiluetic therapy can be made fully only after sufficient time has elapsed to allow these patients to reach the age in their disease when late complications are most apt to occur. None of the new plans have operated long enough to allow that determination to be made on any great number of cases, and one must regard all of this as experimental until that has been fulfilled. These newer therapeutic studies have arisen on sound logic and thus are fully warranted, but they must be looked upon as still unproven.

The modern plans proposed and now undergoing study divide themselves roughly into:

(1) Arsenical plans.
 (a) Intensive.
 (b) Modified intensive.
 (Some of these employ the arsenical alone while others used Bi, fever, or some other media in conjunction.)

(2) Penicillin Plans.
 (a) Penicillin alone.
 (b) Penicillin with arsenical, with bismuth, with fever, or some combination of several.

These studies had their beginning in some work being done by Dr. H. T. Hyman, at Mount Sinai Hospital, in New York. He was studying the cause of reactions produced by the intravenous injection of large quantities of fluid. He found that reactions were proportional to the speed of the injections. He found that large quantities of fluid could be given safely by intravenous injection if the rate of flow was kept slow. He also found that larger quantities of a drug could be suspended in solution and administered safely if the rate of flow markedly was cut down. Thus intravenous drip technique had its origin. Dr. Louis Chargin and his co-workers seized upon this plan for giving more massive doses of the arsenical in a relatively short period as compared with the seventy-four weeks of the continuous alternating plan. They began that work in 1933 with a group of twenty-five volunteer patients who were in primary or secondary syphilis. They were given 4.0-4.5 gr. of neoarsphenamine by continuous intravenous drip over a period of five days and then watched for five years. At the end of this observation period they had lost ten of their original twenty-five patients, but of the remaining fifteen examined 86.6 per cent showed what they regarded as clinical cure.

At this juncture the less toxic Mapharsen came to the market and because of the polyneuritis and hemorrhagic encephalitis which had occurred in their original group, they decided to use this in further studies. As total dosage, through trial and error, they determined on the use of 1,200 mg. of Mapharsen to be given in the same period by the same method. Under this scheme a slightly higher cure rate (91 per cent) was obtained. Then various centers throughout the United States were designated to carry these studies further. Very careful checkups of the patients, both before and after treatment, as well as careful detailed records have been kept.

The plan used consists chiefly in dissolving .24 gm. of Mapharsen in 2,000 cc. of 5 per cent glucose solution and giving this amount by drip technique over a period of eight to ten hours and repeating the same process for five successive days.

Under such treatment reactions of both minor and serious nature have occurred. Among the minor reactions were fever, nausea, vomiting and arm pain. These did not necessitate cessation of treatment. Of serious nature manifestations of nephritis, hepatitis, and hemorrhagic encephalitis occurred which required stopping the therapy.

When arsenicals were employed alone about 80 per cent reached apparent cures and 20 per cent relapsed. However, when injections of water sol-

uble bismuth, given the first, third, and fifth day, were added to the plan the cure rate was raised to 86 per cent. It can be added that some groups report a mortality of one patient to each three hundred, which we would regard as rather high.

A modification of this method which employed syringe method injections of 60 mg. of Mapharsen each every six to eight hours until a total dosage of 1,200 mg. was given (ten days) proved highly hazardous. (Thomas-Wexer).

Another plan, carried over five days, but which allowed the patient to remain ambulatory, carried a fatality of one to one hundred cases so treated. In this scheme the daily dose .24 gm. was dissolved in 1,000 cc. 5 per cent glucose and given in one to one and one-fourth hours' time. (Shaffer).

Other intensive plans of combining arsenic-Bi and artificial fever (one-day plan Simpson and later Jones) have been used. They have had very questionable results.

Of all these intensive plans it must be said that they have their hazards. They are purely a hospital procedure and never can be office routine. Further, it takes an especially picked and trained hospital personnel to care for those cases in the hospital, and therefore it is best done in a public center especially set up for this purpose. This of course eliminates the patient-physician relationship we are striving to hold.

Several modified intensive plans have been proposed that can be carried out as an office procedure without any high degree of hazard to the patient. Of these the twenty-six-week plan seems to be worth considering.

1 to 10 weeks inclusive Mapharsen 60 mg. bi-weekly.
1 to 5 weeks inclusive Bi Subsalicylate 1.5 cc. once weekly.
11 to 16 weeks inclusive Bi Subsalicylate 1.5 cc. once weekly.
17 to 26 weeks inclusive Mapharsen 60 mg. bi-weekly.
22 to 26 weeks inclusive Bi Subsalicylate 1.5 cc. once weekly.

The whole subject of penicillin therapy of syphilis still remains in a rather chaotic state. No unanimity of thought exists as to (1) the total dosage to be used, (2) the ideal interval of hours to be allowed between the giving of the individual doses, (3) the proper number of units to be used in each of the individual injections, and (4) the total number of days over which the therapy should be extended. It is known that the total dosage must be greater and that the period over which it is given must be more prolonged than was used in some of the earlier schemes. That probably explains the clinical and serological relapses that all have observed in some of the ex-servicemen who were treated by some of the earlier plans. In addition to the larger-dosage, longer-treatment plan of penicillin therapy which is developing, there are those who believe that such treatment is productive of better results if supplemented by arsenical or bismuth injections, or when both drugs are used in conjunction with the penicillin. Whether such treatment is done in the hospital or in the home by the physician or by a trained aid, who will see that treatments follow in regular succession throughout the day and night to completion, we still do not have any fully accepted plan to follow and we do not know what the passage of time will show the results of this form of therapy to be. As we all know, reactions can occur (severe urticaria, dermatitis, etc.) and it is known that some fatalities have occurred which probably were due to acute edemas of the brain.

Work is in progress with the beeswax-penicillin preparations which may lead to the giving of a large dose which will have sustained slow absorption and eliminate the multiple dosage method. However in this as well as in all penicillin plans to date, time will tell their value. Thus it would seem that these are still a problem for the research groups, and are not ready for acceptance in general practice.

TUMOR OF RETINA IS HEREDITARY

Retinoblastoma, a tumor of the retina, the membrane of light perception in the eye, is hereditary, according to Harold F. Falls, M.D., of Ann Arbor, Mich.

Writing in the January 18 issue of *The Journal of the American Medical Association*, Dr. Falls points out that both eyes were affected with retinoblastoma in female identical twins. The condition appeared at approximately six months of age in both. Because the parents refused either surgery or x-ray treatment for the pair, a fairly rapid extension of the tumor within the skull led to the death of both children.

Dr. Falls states that "it is my sincere conviction that parents producing any child with retinoblastoma should be strongly urged to stop all child bearing. It is also advocated that any person surviving enucleation for retinoblastoma be sterilized."

PRURITIS ANI

LYMAN R. PEARSON, M.D.

INDIANAPOLIS

PRURITIS ANI, a misnomer in so far as being a disease entity, is really a syndrome denoting various degrees of peri-anal skin changes, including irritation, edema, atrophy, hyperkeratosis, sclerosis, and fragmentation of the corium. It usually becomes a chronic condition, subject to recurrence, with its essential symptom being itching, which varies from slight to most severe. In the more severe forms it is most agonizing, both to the doctor and to his patient.

Characterized by irritation in the peripheral nerve endings, it may have many etiological causes. Bacon's[1] classification is as follows:

I Predisposing
- (a) Psychic (worry or overwork)
- (b) Habits (alcohol or sedentary life)
- (c) Constitutional (diabetes, tuberculosis, gall bladder disease, et cetera)

II Indirect
- (a) Mechanical or Reflex (hemorrhoids, cryptitis or papillitis)
- (b) Infection (1) bacterial, (2) parasitic
- (c) Food (allergies, condiments, et cetera)
- (d) Drugs (quinine, belladonna, et cetera)

III Direct
- (a) Traumatic
- (b) Chemical
- (c) Dermatologic
- (d) Physical (perspiration, lack of cleanliness, et cetera)

Terrell[2] believes that the final offending factor in these cases is practically always a fungus infection. In most chronic cases it is practically impossible to find a definite cause, and symptomatic treatment must be tried.

The peri-anal skin shows redness early. Later there is thickening, fibrosis, and finally, deep folds of skin which are constantly moist, with periods of intense itching; excoriations appear frequently, showing the grooves of fingernails, and secondary infection.

The itching may begin as a tickling or burning sensation, which gradually becomes worse until it is most agonizing, usually much worse at night, preventing sleep, preventing quiet sitting in the daytime. Soiling following defecation markedly irritates the area. Mental exhaustion and physical weakness finally develop in a most serious form. Extension to the labia and the pubic area may follow.

Early treatment is important in these cases. Many can be cured easily in an early stage, which become very intractable after advanced skin changes, due to advance of the infection and improper treatment by innumerable physicians. The causes as outlined above must be corrected in so far as possible. A careful history is most important in an effort to determine a cause.

General treatment includes utmost cleanliness and dryness of this area. Cleansing following evacuations, with cotton or tissue moistened with clear water, followed by hydrogen peroxide, is vital. This may be repeated two or three times daily. No soap should be used at any time. The anus should then be patted dry, not rubbed. Unscented talcum powder may be put on with a puff. Tight clothing should be avoided.

Highly-seasoned foods, fish, nuts, pickles, and alcohol in any form are contraindicated. Fresh air, sunshine and rest are helpful. Phenobarbital in small doses will quiet nervous irritability. Constipation may be controlled with milk of magnesia or sodium bicarbonate enemas. No oils, irritating enemas, nor laxatives should ever be used.

For local treatment the rectal mucosa, crypts and papillae may be painted with silver nitrate, 10 per cent solution, and powdered sulfathiazole blown into the rectal canal. The anal area should be painted once a week with a 2 per cent gentian violet solution. Night and morning the patient should apply lightly a full strength solution of aluminum acetate 5 per cent. All ointments and suppositories should be assiduously avoided, for although they give temporary relief they will aggravate the pruritis. Usually in the early cases this treatment will give marked relief of symptoms.

In the more severe or chronic cases careful inspection may show fissures, inflamed papillae, infected crypts, or ulcerating internal hemorrhoids, which cause an infected secretion which oozes out on the anal surface. These conditions must be removed surgically to effect a cure.

If all apparent causes are removed and cure is not effected, more radical treatment must be instituted. One of the most satisfactory methods is the injection of 40 per cent ethyl alcohol subcutaneously in small amounts all around the anus. This interrupts nerve continuity and allows anesthesia for several months. I have used this in over one hundred fifty cases and have had excellent results in all but three. Another method is the "cloverleaf" undercutting operation of Kallet, where the skin is completely undercut around the anus with cloverleaf areas of skin excised. In any operative procedure it is important to level off the skin by excising the skin folds. Both of these pro-

1. Bacon, H. E.: **Anus-Rectum-Sigmoid-Colon**, by J. B. Lippincott, Philadelphia, 1938.

2. Terrell, E. H., and Shaw, F. W.: Observations on Fungal Infections of the Perianal Skin and Rectum, **South. Med. J., 21**:887, 1928.

cedures obtain their relief by interruption of the nerve supply to this area.

Injection of oil soluble anesthetics under these areas may give temporary relief. Use of oxygen, hydrochloric acid, or even distilled water subcutaneously has given fair results in some cases. Tattooing with mercuric sulfide has given good results in a few cases on whom I have used it.

Vaccine therapy, x-ray exposure, and many other types of treatment have been used by many proctologists with most varying results. Only in extreme cases have I found it necessary to do complete anal excision or vulvectomy. Most cases seen by me have been aggravated and complicated by too much treatment, both by doctors and by the use of home remedies. Early and conscientious study and conservative treatment will give most of these patients great relief with a return to normal.

Conclusions:

1. A careful study of the possible etiology of pruritis ani must be the first approach.
2. Conservative treatment, with gentian violet 2 per cent solution and aluminum acetate 5 per cent to the anal skin, usually gives consistently good results.
3. In severe cases alcohol injections subcutaneously or undercutting operations are advisable.
4. Most cases of pruritis ani are aggravated by overtreatment.

TREATMENT OF GONORRHEA IN THE MALE WITH PENICILLIN*

ROBERT D. HOWELL, M.D.

INDIANAPOLIS

IN 1941 Abraham and others[1] reported that the growth of six different strains of Nisseria gonorrhoeae was inhibited by penicillin in dilutions of 1:2,000,000. The advent of penicillin has inaugurated another era in the treatment of gonorrhea. Sufficient time now has elapsed that we may evaluate better the dosage and ultimate response to treatment by this new agent. Early reports are apt to be too optimistic and this particularly has been true in the past in dealing with eradication of the gonococcus.

This gram-negative organism is in no way a helpless, docile microbe, offering itself for sacrifice on the altar of a new drug, however potent it might be. On the contrary, the gonococcus is aggressive to the extent of rapidly adapting itself to its environment. In retrospect, it is well to pause a moment in memory of the many therapeutic agents which have passed into oblivion: acroflavine, mercurochrome, Corbus-Ferry filtrate, gonococcus vaccine, silver in many of its organic forms, and sulfanilamide. We still are confronted by the same old gonococcus, somewhat bent but unbowed. In view of our past experience it seems logical to assume a conservative attitude in approaching an answer to the true value of penicillin.

The precise way in which penicillin acts to destroy the gonococcus is unknown. It generally is assumed that penicillin interferes with the normal completion of some metabolic transformation, thus inhibiting the development of the cell and leading eventually to its death.[2]

Penicillin is an excellent gonococcal bacteriostatic. The clinical cure occurs as a result of the host's defense mechanism, provided it is not disturbed by too much interference. Florey and Jennings[3] state that the good effects of penicillin depend on simultaneous actions by the leukocytes and other defense mechanisms of the body, which deal with the bacteria while multiplication is held in check by the penicillin.

Penicillin has been administered by a number of methods. Urethral instillation of penicillin has been given adequate clinical trial by Miller[4] and Cohen[5] without any degree of success.

Administration of penicillin by oral preparations may be utilized; however, the dosage is large and clinical results vary to such an extent that this method justifies no further discussion.

Penicillin in saline solution offers the easiest method of administration but of course requires frequent injections to maintain a sufficiently high

* Presented before the Ninth Councilor District Meeting, at Lebanon, on May 7, 1946.

[1] Abraham, E. P., et al.: Further Observation in Pencillin, **Lancet. 2**:177-188, 1941.

[2] Frazier, C. N., and Frieden, E. H.: Action of Penicillin, Especially on Treponema Pallidum, **J.A.M.A., 130**:677, 1946.

[3] Florey, H. W., and Jennings, M. A.: Penicillin—Special Name, **Brit. J. Lug.**, 112 (July) 1944.

[4] Miller, C. P., Scott, W. W., and Moeller, V.: Studies on the Action of Penicillin, **J.A.M.A., 125**:6-7, 1944.

[5] Cohen, D. L., and Grover, M. L.: Ambulatory Sodium Penicillin Therapy of Gonorrhea in the Male, **J. Urol., 53**:815, 1945.

blood level to be effective. Such solution injected intramuscularly is almost entirely excreted in from three to four hours.

Thompson[6] has described a simple method of chilling the area of injection in order to retard the absorption of penicillin by slowing the circulation. This is accomplished by pre-chilling the site of injection for two hours, utilizing an ice bag, which remains in position for twelve hours following the injection. This method is not well adapted for use in office treatment and I have had no experience with it.

Penicillin in beeswax-peanut oil, as developed by Romansky[7], provides a method of prolonging the action of the drug. Commercial preparations are available containing 300,000 units of calcium penicillin per cubic centimeter, which may be injected either intramuscularly or subcutaneously. A single injection of 300,000 units will produce and maintain assayable levels of penicillin in the blood for twelve hours, with excretion of penicillin continuing in the urine for twenty-four to thirty-five hours.[7]

Kirby[8] has made a comprehensive study of this mixture and found a wide variability of absorption and excretion of penicillin in patients receiving intramuscular injections. He found the subcutaneous method of injection provided more uniform absorption and prolongation of blood levels. Sterile abscesses have been reported as a complication; however, I have failed to observe one in my own practice. The literature contains no reports of any abnormal constitutional reactions to the penicillin in beeswax-peanut oil mixture. This type of preparation is ideally adapted for use in the office treatment of gonorrhea.

Penicillin should be administered in relatively large doses initially, so that the gonococcus has no chance to become resistant. The minimum degree of toxicity renders this course harmless, being tolerated much better than the sulfonamides. Thompson[6] believes that a dosage of 150,000 units, administered within a time limit of fifteen hours, is necessary to attain a cure rate of 95 per cent. In my opinion any dosage less than 150,000 units, administered 30,000 units every three hours, has not been satisfactory.

I have found 300,000 units of the penicillin beeswax-peanut oil mixture to be an adequate dosage in obtaining excellent clinical results.

The results of administering penicillin in gonorrhea are dramatic. Approximately seventy-five per cent of these patients have no discharge at the end of twenty-four hours. Usually there is a slight mucoid discharge of sufficient quantity to be observed as a shred in the first glass of the two-glass urine test. The urine is clear and these mucoid shreds disappear in two or three days but may persist for seven to ten days. A hazy urine, persisting longer than twenty-four hours, suggests failure. Careful stripping of the urethra in 75 per cent of these cases will produce discharge, which, if stained and searched thoroughly, will reveal the gonococcus. This is the best method of detecting early failures.

Several factors may play a part in failure. Carelessness in refrigeration and handling may result in a decrease in the potency of the penicillin. Thompson[6] is of the opinion (shared by Sternberg[9] and Riba[10]) that there is a wide variation in potency of various lots of penicillin. This, I believe, has been borne out by clinical experience.

Strains of gonococci vary in their resistance to penicillin clinically as they do in experimental studies in vitro. Frazier[2] states that there is considerable evidence that naturally resistant strains of the gonococcus have been selected by the gradual elimination of the more susceptible organisms through treatment with the sulfonamides. As the process of elimination has continued, gonococcal infections have shown a steadily increasing tendency to become sulfa-resistant. Thus, our past experience with the gonococcus would lead us to expect the gradual development of penicillin-resistant strains.

Resistance of the patient is of greatest importance. The patient must possess the proper defense mechanism in his body to effect a cure.

Complications produce the greatest number of failures to an initial course of penicillin. These, in order of frequency, are the common complications: periurethritis, prostatovesiculitis, epididymitis, and urethral stricture.

The presence of complications can be determined by a careful history, physical examination, and use of the two-glass urine test. The presence of pus in the second glass indicates posterior urethral involvement, the extent of which may be determined by rectal examination of the prostate and seminal vesicles. Periurethritis commonly occurs along the ventral surface of the urethra and may be detected by palpation. The exquisitely tender and painful epididymitis is rarely overlooked. I do not delay urethral calibration when indicated. If gonococcal foci exist in either periurethral or prostatic tissues the precedure of urethral dilatation or prostatic massage may be carried out with reasonable safety during periods of adequate penicillin blood levels. Generally such procedures may be deferred until twenty-four hours or more following the initial injection of penicillin.

[6] Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, **J.A.M.A.**, **130**:617-636, 1946.

[7] Romansky, M. J., Murphy, R. J., and Rittman, G. E.: Single Injection Treatment of Gonorrhea with Penicillin in Beeswax-Peanut Oil, **J.A.M.A.**, **128**:404-407, 1945.

[8] Kirby, W. M.; Leifer, W.; Martin, S. P.; Rammelkamp, C. H.; and Konsman, J. M.: Intramuscular and Subcutaneous Administration of Penicillin in Beeswax-Peanut Oil, **J.A.M.A.**, **129**:940-944, 1945.

[9] Sternberg, T. H., and Turner, T. B.: The Treatment of Sulfonamide Resistant Gonorrhea with Penicillin Sodium: Results in 1,686 Cases, **J.A.M.A.** **126**:157, 1944.

[10] Riba, L. W.; Schmidlapp, C. J.; and Bosworth, N. L.: Use of Penicillin for Gonorrheal Resistant to Sulfonamide Compounds: Report of 450 Cases, **War Med.**, **6**:72, 1944.

I have experienced no penicillin-resistant gonococci to date. There have been failures, which required one to two subsequent courses of penicillin because of "primary failure" or the presence of a complication. Penicillin is the drug of choice and its effect on both the gonococcus and the patient far exceeds results obtained with the sulfonamides. The results tabulated from current medical literature are in general agreement. Perhaps the most carefully reported series is that reported by Koch and others,[11] who record a failure rate of 14 per cent in a series of 485 patients treated by an initial course of 200,000 units. No case of complete penicillin-resistance was encountered. They call attention to the limitations of penicillin therapy and the possibility of producing a carrier state if patients are not carefully followed for a sufficient period of time.

In evaluating results in the treatment of gonorrhea one must define "cure." The standards for criteria of cure which have been evolved through years of practical clinical experience must not be discarded. Failure rates and relapses with reinfection will increase unless we meet the criteria of cure.

1. The patient must be completely free of all clinical manifestation of the disease.
2. Careful search must be made for gonococci in persistant morning drop.
3. The employment of a provacative sound 48 hours following the course of penicillin and repeated at seven-day intervals for four weeks.
4. Prostatic massage at weekly intervals for four weeks with absence of pus and gonococci.
5. Pus-free first glass urine.
6. Observation for six weeks.

It is well to advise these patients of the need of repeated serological examinations of the blood for syphilis, since masking of early syphilis has occurred coincidental with the treatment of gonorrhea with penicillin. The Army has advised that such tests be continued monthly for one year.

The following five cases will illustrate the previous discussion:

Case 1—Gonorrheal Urethritis: H. M., age forty-eight, had a profuse urethral discharge for two days, which, on examination, contained many gonococci. His first glass was turbid, with shreds, while the second glass was clear. Three hundred thousand units of penicillin beeswax-peanut oil were injected intramuscularly. His discharge ceased in twelve hours and became mucoid in type, which was seen the next day. A smear revealed no gonococci. The first urine was clear with an occasional mucoid shred. The third day the mucoid discharge had disappeared and the urine was free of pus. Provocative sounds and prostatic massage over a four-week period have failed to produce relapse or recurrence. This case represents the ideal response.

Case 2—Gonorrheal Urethritis: E. O., age twenty-four, had his profuse urethral discharge and dysuria for one week. Following administration of 300,000 units of penicillin beeswax-peanut oil, the discharge became mucoid in twenty-four hours. The first urine glass was hazy, with shreds, but no gonococci could be demonstrated in the smear. The urine was again hazy on the third day, but again the smear was negative. Gonococci were demonstrated in the smear on the fourth day, though the urine was clear, with one shred. An additional 300,000 units of penicillin beeswax-peanut oil were administered intramuscularly. The following day there was no discharge and the urine was clear and free of shreds. Subsequent provocative measures have been carried out with negative results. This case represents a primary failure and may be attributed to a decrease in drug potency, lowered resistance of the patient, or an experienced gonococcus with good resistance. The persistance of a hazy urine and mucoid discharge indicated the possibility of failure and the necessity for careful search for the gonococcus.

Case 3—Gonorrheal Urethritis, Periurethritis and Prostatitis: P. M., age twenty-six, presented a urethral discharge of five days duration. During this period he had received large doses of sulfathiazole, with no improvement. During the previous twelve hours he became aware of some pain along the base of his penis, with burning on urination. The smear contained gonococci, and both the first and second glasses of urine were cloudy. A swollen, tender periurethral gland one centimeter in diameter was palpated on the ventral surface of the anterior urethra. The prostate was slightly enlarged and moderately tender. Three hundred thousand units of penicillin beeswax-peanut oil were injected intramuscularly. The following day the scant discharge was mucoid in type. The first urine glass was hazy, with an occasional shred; the second glass was clear. The periurethral gland had decreased in size and was not tender. The third day an occasional gonococcus was found in the smear of the scant mucoid discharge. The first urine glass was clear with shreds; the second urine glass was clear. The periurethral gland had decreased to less than half its original size. A number 22 F. sound was introduced and the periurethral gland thoroughly massaged over the sound. Three hundred thousand units of penicillin beeswax-peanut oil were administered. There was no reaction, and on the fourth day the first urine glass was clear, with shred; the second glass, clear. The shreds were absent on the eighth day. Subsequent provocative measures indicate a cure of this patient. This case illustrates the persistence of gonococci from a periurethral gland after initial penicillin therapy, and the response to drainage and subsequent penicillin. Introduction of a sound

[11] Koch, R. A.; Haines, J. S.; and Hollingsworth, W. Y.: Evaluation of Penicillin in Gonorrhea Treatment and Control, **J.A.M.A., 129:**491-495, 1945.

in this type of case in the pre-penicillin days would have been fraught with danger.

Case 4—**Gonorrheal Urethritis and Epididymitis:** J S., age twenty-four, who had been taking sulfathiazole for twelve days, with little or no improvement, had a left epididymitis develop twenty-four hours previously. His smear was positive, both urine glasses cloudy. The left epididymus was slightly swollen and very tender. Three hundred thousand units of penicillin beeswax-peanut oil were administered and a suspensory applied to the scrotum; twenty-four hours later no gonococci could be found in the smear made from the scant mucoid discharge. The first urine glass was cloudy with many shreds; the second glass was hazy. There was less tenderness and swelling of the epididymus. I debated whether to administer another course of penicillin, but chose to wait another day. Much to my surprise, the third day revealed a clear urine, with one shred in the first glass, while the second glass was clear. There was no discharge. By the tenth day the epididymus was normal to palpation, and subsequent massage and urethral dilatation have failed to produce a relapse. This case represents a delayed response on the part of the patient to the gonococcus, or a gonococcus which was very sensitive to penicillin.

Case 5—**Gonorrheal Urethritis, Urethral Stricture, and Prostatitis:** O. D., age thirty-eight, presented himself with an intermittent urethral discharge of two months duration. During this period smears had remained positive despite two courses of penicillin, 120,000 units, given 20,000 every three hours. There was some burning on urination, with localized soreness along the urethra. He admitted a gonorrheal infection sixteen years previously, following which he developed urethral stricture. He denied exposure following his previous penicillin therapy. The smear was positive, while the first urine glass contained pus and shreds, the second glass pus. The prostate was swollen and very tender. Three hundred thousand units of penicillin beeswax-peanut oil were administered. One day later his discharge was scant, but gonococci persisted. The first urine glass was hazy, with many shreds, the second urine glass clear. A 22 F. urethral bougie was introduced which revealed multiple urethral strictures. The prostate was gently massaged. The second 300,000 units of penicillin beeswax-peanut oil were administered. Subsequently there was no urethral discharge and the urine was clear but contained shreds. This patient has been under observation for two months, receiving periodic urethral dilatation and prostatic massage and has remained free of his infection. This case again points out the need for searching for gonococcal foci and their eradication, along with repeated penicillin therapy.

The effect of penicillin on the gonococcus is dramatic, however it is not enough to expect every patient presenting himself with such an infection to recover with a single course of treatment. Failures do occur, as is illustrated by the second case; however, subsequent therapy effected the cure. These patients deserve a very careful follow-up if we are to obtain the best results. Careful search for gonococci in the patient with the "morning drop" or hazy urine will reveal the need for additional treatment, as is illustrated by the cases cited above. Complications are no longer dreaded as they were in the pre-penicillin days, however they do require recognition and treatment. Penicillin alone is no substitute for the cold steel of a urethral sound, or the gentle pressure of a finger slipping over the prostate.

I have purposely avoided discussion of procedures which cannot be undertaken in the office diagnosis and treatment of gonorrhea in the male. Cultural methods, either for diagnosis or cure, are not necessary, in my opinion, provided care and diligence is used in searching for the gonococcus in a well-prepared smear. My experience in employing penicillin in saline is comparable to that of the penicillin beeswax-peanut oil mixture. I chose to employ the latter preparation, since it requires one injection and affords equally good results.

AMERICAN ASSOCIATION OF INDUSTRIAL PHYSICIANS AND SURGEONS

The 32nd Annual Convention of the American Association of Industrial Physicians and Surgeons will be held April 27 through May 3, 1947, at the Statler Hotel, in Buffalo, New York.

Details of the meeting and a copy of the preliminary program may be obtained from Dr. Edward C. Holmblad, Managing Director, American Association of Industrial Physicians and Surgeons, 28 East Jackson Boulevard, Chicago 4, Illinois.

Hotel reservations should be made through the Housing Bureau, Buffalo Convention and Tourist Bureau, Inc., 602 Genesee Building, Buffalo, New York.

MENTAL HYGIENE FOR THE GENERAL PRACTITIONER*

S. T. GINSBERG, M. D.

MARION

Mental hygiene has gripped the imagination of the general public as well as the medical profession. Many books and articles, scientific and popular, are leading us all to an awareness of the great need for mental hygiene.

Just what do we mean by mental hygiene? It is a big term. It covers a tremendous territory. We might put it in very simple form and say that it means an attempt to maintain mental health and prevent mental illness. It aims to develop self-understanding, with which the individual has more opportunity to achieve the fulfillment of his potentialities, and to prevent those conditions which might impair the mental health, the happiness, and the adjustment of the individual and the group. Mental hygiene is the common meeting-ground of psychiatrists, the entire medical profession, psychologists, sociologists, economists, and also involves education, religion and the arts.

All of us have been startled, in the last few years, by the high incidence of induction board rejections for neuropsychiatric disabilities, the high percentage of neuropsychiatric casuals of the armed forces, the high juvenile delinquency rates, increasing criminalism, high divorce rate, and other evidences of personality maladjustments.

The present trend in medicine toward preventive treatment is one that is applicable not only to physical conditions, but to mental conditions as well. As the application of the new knowledge in the medical sciences has greatly enhanced physical health, so, too, the application of our increased knowledge of psychiatry and its allied sciences can enhance mental health. The increasing interest of the medical profession in behavior problems is opening the way to a better understanding of the problem of mental illness and the therapeutic and preventive measures necessary to meet it.

The mental hygiene movement was begun in 1908 by Clifford Beers, who, following a psychotic experience, was led by Adolf Meyer to turn his energies and talents to improve treatment and prevention of mental illness. Beers' book, "*A Mind That Found Itself*," and the formation of the National Committee of Mental Hygiene, in 1909, ushered in a movement which has since assumed international significance. The purpose of this group is to prevent the development of mental illness and delinquency through educational measures, and the earliest possible recognition and treatment of personality disorders before hospitalization or penalization would become necessary. As a result, many mental hygiene clinics have been organized, the principles of mental hygiene and child guidance have been adopted by many schools and colleges, juvenile courts, parent-teacher groups. Extensive research and educational projects have been sponsored.

Because of the wide scope of mental hygiene there have been many other efforts to meet its problems: crime prevention programs, child guidance programs and clinics, family relations clinics, visiting teacher projects, social service works, welfare agencies, boys clubs, big sister services, mental hygiene clinics, and co-ordinated programs of city, county, state and national scope. As an example, recently the National Institute of Social Relations was incorporated, as a non-profit educational organization, to launch a much-needed series of group discussion programs for use at the community level. The Institute publishes weekly discussion guides dealing with vital issues of the day. The subject matter varies widely, from problems of youth, veterans, women, labor, housing, unemployment, and discrimination, to atomic energy. All of these are vital in the field of mental hygiene.

Before one can understand the problems of maladjustment and its prevention, he must know something of the modern concepts concerning the mind and emotions. At the risk of repeating some things you already know, I am going to touch lightly on the personality structure, mental mechanisms, and causes of maladjustment.

An infant is born with certain physical, instinctive and emotional potentialities. He has inherited his fundamental body makeup and certain latent psychic factors. His mentality is formless, and has been called lawless. This mentality is what Freud[1] terms the id. When this id comes in contact with reality and is forced to learn the dangers of the environment and the fact that it cannot always have its way without pain or punishment, then part of this id becomes modified into what we call the ego. Soon thereafter, through the influence of the parents and society, a knowledge is acquired of social conceptions of right and wrong; that is, a conscience. This Freud calls the super-ego. The personality structure thus is made up of an unconscious and a conscious element. The unconscious is a living, dynamic, motivating system of mental processes, capable of independent existence, and not subject to the laws of logic or related to reality. It contains emotionally charged ideas or complexes. It also contains all of our infantile impulses. There is a continual striving on the part of the repressed instinctive tendencies of the

* Presented before the Eleventh Councilor District Meeting, in Marion, on September 18, 1946.

1. Brill, A. A.: *Freud's Contribution to Psychiatry*, New York, W. W. Norton & Co., 1944.

id to escape, to express themselves in spite of the prohibition of the ego and super-ego. These prohibitions are dictated on the one hand by the requirements of reality, and on the other hand by the strictures of the super-ego—"The part of the parental and social ideology that has been incorporated into the psychic system, the still small voice." It is the task of the ego to adjust instinctive drives to the internal and external rules.

The conscious mind is only a small part of the psyche.[2] It attempts to control voluntary activity, both psychic and muscular. It contains our coherent organization of mental processes. It serves to test reality, to orient us, to attempt to make our behavior appropriate, on the basis of past experiences consciously recalled. To understand the link between the unconscious mind and the conscious mind, we must understand certain techniques or mental mechanisms used by the personality in connection between the two.

An understanding of repression is essential in the structural and dynamic approach to mental processes. Psychoanalytic investigations have shown that fear is the motive power behind all repression. However, this fear is by no means a rational or entirely conscious fear of external or actual danger, but an inner fear which appears in consciousness as a guilty conscience. There is constant conflict between the impulses seeking expression and the repressions holding them down. This causes much discomfort and anxiety. There are a number of ways in which the personality tries to resolve its conflicts. One of the common ways is called sublimation. Energy arising within the unconscious, attached to an unacceptable impulse, is pushed down again and transferred to something acceptable. Thus a sexual drive unaccepted by society or the individual's ego is repressed and sublimated into an acceptable creative drive. There are many of these normal mechanisms, such as projection, in which a solution to a conflict brought about by self-criticism is to lodge the fault at someone else's door; that is, to project it outside of the personality. This is not only a normal mechanism, but a common one in the development of hallucinations and delusions. Interjection is to award ourselves the virtue of another; we identify ourselves with the hero of a movie. Another example is the little boy who follows the profession of his father. Rationalization is another common mental mechanism utilized by all of us frequently. We explain away our faults plausibly, but without reference to the unconscious reasons or without loyalty to the facts.

There are many other such mechanisms which are utilized unconsciously and which help us in overcoming our conflicts. One which is common in the formation of hysterical symptoms is conversion. This is the conversion of strong emotional feeling into a physical symptom, yet with no recognition of the relationship. For example, a person has to go to an event which he dreads, and on the day of the event he will develop a headache which prevents his attending. The headache is in no way consciously planned or preventable, yet it serves a purpose. The psyche prefers the physical symptom. Similarly, paralysis and loss of sensation, loss of speech and partial or complete loss of vision, amnesia, as well as many functional physical complaints, like low backaches, may be conversion symptoms.

Another common mechanism is displacement. The emotional value attached to one idea or person is transferred to another idea or person. An important type of displacement is transfer in which a person unknowingly identifies another with a previous associate and reacts toward him accordingly. A man takes an immediate dislike to his new boss; he doesn't know why. He doesn't consciously recognize the fact that the new boss reminds him of his father, whom he has always hated or feared.

In the well-adjusted individual, the conscious personality keeps the unconscious personality under control. In order to understand the personality, we must understand all of it, the unconscious as well as the conscious mental mechanism. We must understand the physical makeup of the individual, and his behavior within his environment. We recognize now that we cannot separate the psyche from soma. They are too intimately related. Also, we cannot separate the personality structure from the environmental factors. Behavior is the result of interplay between personality and environmental factors.

The goal is a harmonious and effective personality, wherein an individual is able to accept himself and the conditions of his life with fairly persistent satisfaction, is normally acceptable to others as a companion and co-worker, and is, with reasonable assurance and cheerfulness, able to take his part in life with interest for himself and benefit to society. To achieve and maintain this harmonious personality in the individual, and thus to achieve and maintain a harmonious and effective society, are the goals of mental hygiene.

The mental mechanisms are defensive and protective, and are means of economizing psychic energy. They are the methods of maintaining the proper adjustment of the personality in its environment. Any of these modes of personality adaptation may take forms that produce abnormal behavior and maladjustments. Stresses, disappointments, adversities, difficult tasks, create a strain upon the compromises which ordinarily suffice to maintain balance in the personality structure. A person is aided in solving his problems by a normal amount of anxiety, but excessive anxiety may result in maladjustment.[3] Often psychic traumas of childhood, forgotten by the individual, may be re-enacted by a similar experience and precipitate

2. War Department Technical Bulletin (T. B. Med. 12), *Lecture Outlines for Officers on Personnel Adjustment Problems*: Washington, War Dept., 1944.

maladjustment or mental illness. Precipitating factors may be psychological stresses leading to frustrations, disappointments, accumulative irritations, emotional losses, and physical or physiological extra burdens. The precipitation of maladjustment or mental illness may be due to psychic conflict, a breakdown in the relationship between the ego, the super-ego, and the id, or a disorganization of the ego. Physical illness also may precipitate maladjustment or mental illness. The individual becomes irritable, aggressive, develops fears, or his physical health also may suffer. He may develop psychosomatic symptoms without recognizing that the illness has anything to do with his nervous stress.

What role can the general practitioner play in this field? The general practitioner can and should assume a major role in mental hygiene because of his close contact with the individual, with the family, and his position in the community. He has the confidence of his patient and of the community. He is in a position to help and guide his patients, and can help in the co-ordination of all the various efforts by the different groups interested in mental hygiene.

Some of the various principles of mental hygiene of special importance to the general practitioner will now be discussed briefly. There are certain special periods of stress and certain essentially important periods of development which must be understood.[4] Of course, there can be no let-down in our attempts to understand human behavior at any stage of life, but the following basic ideas may be useful.

The Child: First, we should emphasize that each child is entitled to a normal, healthy start in the world. Its parents should be well-adjusted, economically secure, and anxious to have their child. The pregnancy should be watched closely so that the fetus develops normally. The delivery especially is important. Birth trauma, prolonged apnea, with its cerebral anoxia, should be prevented. Studies have shown that many problem children have a history of prolonged apnea, were blue babies, or had difficult deliveries. There is no period in life more important in molding character and personality than early childhood. The child is completely helpless and must depend entirely on his parents for all material and emotional wants. A child must have the love, warmth, food and security given by fond parents. Inadequate parental love and too rigid schedules may produce anxieties and insecurities that may stay with the child for life. The opposite extreme is equally disastrous. If the parents overindulge and spoil the child, he may grow up selfish, inconsiderate, demanding, and bound to suffer rebuffs and disappointments.

School Days: Here the child's training is shared by the parents and teachers and there must be full co-operation and understanding. While educational attainments are important, it is even more important that the child be taught to take his place in groups, to learn tolerance and fair play, to acquire ideals of honesty, to learn to co-operate with others, and learn to serve others. Educational experiences from kindergarten to college should be directed not only toward developing the child's intellectual abilities, but also toward preparing him to be a socially adapted, happy individual, who can become a free, decent and responsible citizen in a democratic society. It is also important through these formative years to consider the child's physical health. Contagious diseases have resulted in encephalitis, producing profound personality changes, leading to maladjustment and mental illness.

Adolescence: In the development of the child, sexual impulses and urges create new problems in adolescence. The boy must be given simple, common-sense explanations about his sexual functions; otherwise, he is apt to develop excessive fears which may haunt him endlessly and lead to severe conflicts. The girl, too, must be properly prepared. She must be given simple, common-sense explanations about her feminine functions; otherwise, she may be frightened and disgusted by normal sexual functions and may acquire a disastrous attitude that will endanger her future role as a wife and mother. There are other problems of adolescence. Children of this age may be very idealistic, may become too highly competitive in sports and school, may show resentment of authority, may take minor slights and failures seriously. The general practitioner can help the parents and teachers handle these emotional excesses with patience and understanding. They must sustain the child's security, overcome his anxiety, restore his self-confidence and reorient his social goals. Punishment, when needed, should be just and direct, never cruel or vindictive. We must always remember that the adolescent's problems are emotionally charged with intensive strivings, frustrations, and deep unhappiness. If these problems are not handled well, many of them will continue and the child will withdraw into unhealthy daydreaming, seclusiveness, or become anxious, tense, rebellious and delinquent. The general practitioner is frequently consulted in regard to the child's education and career. We must remember that plans should be in keeping with the child's mental and physical capacity, that they must be suited to the child's individuality and in keeping with the economic means of the family. Sober evaluation of all these factors is necessary, as striving beyond the child's potentialities may lead to failure and maladjustment.

3. Masserman, J. H.: *Principles of Dynamic Psychiatry*, Philadelphia, W. B. Saunders Co., 1946.

4. Masserman, J. H.: Psychiatry, Mental Hygiene and Daily Living, *Mental Hygiene* 29: 650-655 (Oct.) 1945.

Marriage: The general practitioner can play an important role in marriage counselling. Marriage calls for a serious change in environmental, economic and emotional factors. Both partners must sever themselves emotionally from their respective families, they must learn to understand each other, they must turn to each other for sharing and planning, and the cultivation of common interests and goals. Sex adjustment in marriage is important, of course, but this probably has been over-emphasized. A child who has grown up under the right guidance, has reached sexual maturity, and has learned to like and get along with his mate, will find the sexual relationships, in nearly all cases, to be satisfactory. You often are asked by a couple who is adjusting poorly whether they should have a child in order to hold the marriage together. A child will rarely serve such a purpose. It will usually add to the conflicts and stresses and lead to further disagreements. The child, too, should be considered, as he is entitled to a happy, stable home, without antagonism, resentment, fear and anxiety.

Industry: Industry itself is growing more aware of the importance of mental hygiene. Psychologists are employed to guide the individual in the selection of his position and type of work. The individual must be suited by temperament, intellect, and physical capacities to his job. He must feel secure, he must obtain a feeling of satisfaction, and of being an integral part of important activities. He must feel that his individuality is respected and that his future is secure. Experience has shown industrialists that good mental hygiene means good morale and increased efficiency in production.

Social Life and Recreation: "Man does not live by bread alone." Recreation, exercise, relaxation, entertainment in groups, all help to increase the zest of living, and help in overcoming anxieties, tensions, aggressive tendencies and fears.

The Veteran: Millions of veterans are returning to their homes. They must not be overindulged, but they do need assistance in their readjustment. Educational programs and occupational re-training are important, but more important is the security and love of their families. They should be urged to assume responsibility in the support of themselves and their families. They should be urged to take part in group activities and should be offered leadership in organizations and community affairs.

Middle Age: There has been an emphasis of endocrine dysfunction and loss of physical capabilities in middle age. However, even the sexual functions do not cease suddenly; there is a gradual readjustment to the changing situation. Endocrine therapy is indicated in a small percentage of cases, but the major problem is one of mental hygiene. In middle age, there is a period of reflection, of reviewing accomplishments, youthful ambitions, limitations, and failures. Youthful ambitions are given up. Feelings of depression are common. Children leave the family group, the home becomes cheerless and bleak. Many people resent growing old. They seek vainly for youth, by excessive work, strenuous sports, or extra-marital indulgences. With proper assistance, this period of life can be most gratifying with pride and pleasure in the children, their accomplishments and happiness. There can be a closer relationship between married couples of this age group, with mature interest, social and religious life and cultural pleasures.

Senescence: The great increase in neuropsychiatric hospital patients in institutions is due primarily to the greater percentage of our population reaching the senescent age and the high percentage of mental illness in this group. We find organic changes in the brain due to arteriosclerosis, hypertension, and the great gamut of physical ills of this group. In the organic disease group of this age, as in all organic diseases, mental hygiene plays an important role. Here, too, the depressions of frustrations, failures, loss of loved ones, loss of security, feeling discarded and unwanted, lead to severe maladjustment and mental illness. These individuals, with proper guidance and understanding, can learn to live happily and contentedly in spite of having physical infirmities. They can learn to adjust their lives to their bodily and emotional limitations.

In conclusion, I wish to emphasize the importance of the vital role the general practitioner can take. He can help most patients overcome mild behavior problems and maladjustments if both patient and doctor recognize them as such. He should recognize early the more severe maladjustments and mental illnesses which require the more intensive psychotherapy of the psychiatrist, and recognize early the frank psychosis needing institutional treatment. His close personal contact with the individual and relationship of the family puts him in a strategic position to recognize the early stages of behavior disorder and to initiate appropriate corrective measures. He can aid in educating the public in the principles of mental hygiene. He can sponsor mental hygiene programs and can assume an important role in co-ordinating all the various groups and projects in this effort. The general practitioner can assume a dominant role in this effort to improve the individual's physical and mental health, his adjustment in the group, and thus maintain a better and healthier society.

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

The Fourth Stage of Labor

In 1943 hemorrhage became the main cause of death associated with childbirth in the United States. When one considers the effect of acute anemia upon the susceptibility to infection which may be the cause of death, the importance of hemorrhage is greater as a secondary cause of death than is now accorded to it.

The blood loss during pregnancy associated with abortions, placenta praevia and abruptio placentae is of first magnitude, but of special interest is the blood loss during what is generally considered the third stage of labor and the first one or two hours following the delivery of the placenta.

It has been suggested* that the time following the delivery of the placenta be given the distinction of a separate stage of labor, the fourth or dangerous stage.

Hemorrhage at this time may be indeed a tragic condition when, following the successful birth of a child and deliverance of the placenta, sudden hemorrhage and shock result in death of the mother because of lack of watchfulness on the part of the attending physician or nurse, or because of lack of proper facilities to control sudden hemorrhage and combat shock.

Too often the busy physician leaves the hospital or bedside of the new mother as soon as the placenta is delivered and the repair made. Too often the patient is alone in her room without a nurse watching for evidence of flooding or unrevealed uterine hemorrhage. It is imperative that oxytocic drugs be at hand when needed and that plasma be immediately available to maintain the patient until whole blood for transfusion can be obtained.

Certain factors of importance to prevent postpartum hemorrhage are:

A uterus that is surely clean of the placenta and membranes; complete knowledge of and repair of all wounds resulting from the birth of the child; administration of the proper oxytocic drugs and uterine packing, if considered indicated, following delivery; avoidance of unnecessary or injudicious massage of the uterus, such as may prevent or disturb proper uterine blood vessel thrombosis and the normal tamponage effect of the postpartum blood clot within the uterus; the ready presence of the attending physician or capable representative until the danger period is past.

* Greenberg, E. M.: *Am. J. Obst. & Gynec.* 52:746 (Nov.) 1946.

"GOODBYE TO THE GRAIN"

The title to this editorial is borrowed from the December number of *The Journal of the New Jersey Medical Society;* it fills a long-wished-for need, a means of expressing just what we think about a matter of the utmost importance to a large group of medical men who graduated years ago, say forty years or more.

Some time ago we noted, with no little misgiving, the announcement that the Pharmacopeia Committee had reconstructed its conversion table; we are no longer to use the grain as the unit—we *must* use the gram! We have hesitated to make any comment on this, lest we be accused of being a bit hidebound, too much concerned about the things we were taught more than four decades ago, too little interested in modern progress. But now that the New Jersey editor, years younger, has expressed his opinion, we feel that we may, at long last, come out into the open.

The apothecary system has been in use for a long time; even today most of us think in terms of grains, drams and ounces, and to have a single committee tell us we are "all wet" and will have to change our ways—well, it just is unthinkable!

Oh yes, we recall that in our student days we were told just how to make these conversions, but down through the years practically everyone has used the apothecary system and now we are told to hop over onto the metric side and forget all we ever knew about dosage, under the old system. As the New Jersey editor succinctly points out, it is much easier to say—and write—1/100 grain, rather than a sixty-thousandth of a gram. We occasionally call for 1/400 grain, which but adds to the complexity of the picture, and to delve into milligrams would seem a bit too much for the average chap *who never knew any better!*

Nor is this all; when it comes to liquid dosage the problem seems even more complicated. Again quoting the New Jersey course, we learn that a three-ounce mixture takes care of the dosage for a week, "a teaspoonful after meals." As he so cleverly states it, one would need a modern slide rule to compute such a prescription.

Of course we could say "minims" instead of "drops," but here again habit steps in. The ounce mark has been ours for centuries. No one else dared use it for private purposes; now it is to go into the discard, into the limbo of forgotten things.

Oh, well-a-day; we probably shall go on for the remaining years of our life using grains, drops, drams and ounces, just as though we never had heard of any other nomenclature and, just as probably, we will be set down as a die-hard, or something of that sort. Had there been declared a moratorium, giving us sufficient space of time to reorient ourselves we may have felt differently about such matters, but as things are, we simply are a bit rebellious.

Civilian Practice in War Time

Recently the American Medical Association, through its proper committee, sent out a questionnaire to several thousand medical officers in the late war. Now this committee on National Emergency Service of the A.M.A. has prepared one for those who were in civilian practice during this period. Already some 5,000 such inquiries have been mailed and each recipient is asked to fill it out completely, and return at the earliest convenience.

Practice of medicine in times of war is far different from that in normal periods, as all are aware. This is true not only in the case of those in service but of members of the "home guard," as well. Problems arose in both instances, problems that should be studied and solutions worked out.

In this civilian practice program the main theme is "How was the at-home population served during World War II?" Were there instances of a shortage of physicians, nurses and hospitals? What changes are to be recommended in the mobilization of medical services in future emergencies?

This new questionnaire first asks the usual questions about the type of practice in which civilian physicians are engaged—a very important question being the size of the community in which the physician was located during that period. One is asked as to his activities in Selective Service work, the actual number of hours in which he was thus employed.

One of the questions seems to us a paramount thing—"Do you feel that you and your fellow civilian physicians could have served your community in a reasonably adequate manner if there had been a large scale epidemic?" If a negative answer is given to this question, one is asked to state whether this was due to a shortage of physicians, nurses or commonly used drugs and equipment.

Another question of importance is whether one believes that induction into service brought too great a shortage in nursing and hospital care.

Then one is asked to express his opinion re the organization of a Board, representing the medical profession, in case of another emergency. Just how should this Board be made up? Shall it be composed of military physicians, civilian physicians, or both? In this connection one is asked whether he favors Federal legislation covering medical services in war time; if so, just how far should this be carried out?

The questionnaire is not too long and is one that can readily be made out by any physician, without too much trouble. It is hoped that all who received these will answer at once, that the information thus received can be compiled and some definite plans for meeting emergencies be worked out. As we all remember, this War found us wholly unprepared; our members were willing to render

service in almost any capacity, but there was no sense of *organization,* no authoritative source from which the proper advice might be had. Under the proposed arrangement all this will be taken care of and we will be able to meet any emergency that might arise.

The Hurty Biography

For some eight years past Dr. Thurman B. Rice has engaged his spare time—some not so spare—in the writing of the biography of John Newell Hurty, M.D., a real pioneer in health matters. This material appeared in the Bulletin of the Indiana State Board of Health, ninety-six chapters of four pages each having appeared in this publication. It has been our pleasure during these years to read every one of these pages, many of which brought to mind personal recollections of some of the events recorded. We are proud to have known Doctor Hurty, proud to have been asked to confer with him on this or that matter pertaining to health problems; we are one of those who had an abiding faith in his pronouncements, though we shall have to confess that at times we wondered if he was not a few years ahead of his time!

Doctor Hurty's path was in no sense a rosy one; he made enemies and there were those who scoffed and sneered at his theories, but we of today know he definitely was on the right track; many of his "theories" are factual entities, as of today.

Doctor Rice is to be accorded due praise for the work he has put in in bringing to our attention work of this truly great man, this pioneer in health work. It has meant a lot of research, a lot of time in running down this or that phase of a busy career—and it has meant some personal expense.

But now that the work has been completed it remains to be seen what can be done to preserve this historical career in some tangible form. The complete work, according to Doctor Rice, would mean a volume of some 1,500 pages, much too long for practical use. However, it can be abridged into a much smaller volume, say into the ordinary book form.

But this, like all other things, will cost money, and as Doctor Rice quaintly puts it, "We need an 'angel' to complete the project." This "angel" would need to put up, say $3,000, to complete the project.

It is our opinion that here is an opportunity, indeed; an opportunity to preserve, in book form, the work of a real pioneer in health matters. Doctor Hurty, while an Indiana man, was nationally—yes, internationally known; he was recognized as a "health officer" of distinction and we of today are putting into practical use many of his teachings.

Would that some means might be found to publish this abridged volume, that future students of public health might be able to utilize the many facts set forth by this eminent Hoosier, John Newell Hurty.

C.M.A.B.

The above initials, which are not familiar to most members of our profession, represent an organization of the greatest importance to all state medical journals; it means the Cooperative Medical Advertising Bureau, brought into being some twenty-odd years ago by the Board of Trustees of The American Medical Association. In the early days of state journals advertising was gained in many different ways, chiefly by solicitation on the part of the editor or the managing editor. It was the idea of the Board to create a central bureau, under the management of a director, whose job was to get advertising for all member journals. As of today there are thirty-five members of the Co-Op, with a full-time director, Mr. Alfred Jackson, his office being at A.M.A. headquarters.

For some years the Co-Op was in the hands of a small committee, two of whom were A.M.A. officials, the third being Dr. Walter E. Vest, of Huntington, West Virginia. No formal meetings of the committee were held and as a result it became a one-man committee. Journal members had little or nothing to say as to its operations.

A few years ago a small group of editors, less than half the total number interested, began to cast about for ways and means to put the Co-Op on a firmer basis and permit journal members to have something to do with its operation. We requested a special meeting, attended by a surprisingly large group of interested folk, and discussed the situation. The meeting finally resolved into a plan to have an "election" of three editor members of a special committee. Walter Vest, of Huntington, West Virginia, Stanley E. Weld, of Hartford, Connecticut, and the writer were named in this election. Later on we asked for a larger committee and finally got permission from the Board of Trustees to that end. In addition to the three already named, L. Fernald Foster, of Bay City, Michigan, and John Bouslog, of Denver, Colorado, were added to the committee.

Several meetings were held before we were able to announce an official program for the Co-Op, but this finally was done. About this time it became necessary to make some changes in the management personnel, at which time Mr. Jackson was named as Director of the Co-Op, as well as secretary of the Advisory Committee. Two or three A.M.A. officials were named as *ex-officio* members, so at long last the Co-Op came into the hands of its real owners, the thirty-five state medical magazines.

That these changes were for the better is evidenced by the fact that our gross advertising grew enormously these past two or three years, until at the present time it totals some *six hundred thousand dollars per annum!* Quite a corporation, that!

Members of the Advisory Committee are elected by the member journals, the newly-elected man to serve for five years; no member can be re-elected, thus bringing "new blood" into the or-

ganization each year. The new member for 1947 is Dr. Julian Price, of Florence, South Carolina.

We felt our members might be interested in a sketch outline of just where our major advertising income originates, as all are aware that if it were not for advertising no state journal could long exist. Checks covering the "dividends" are regularly mailed to all member journals and all the "book work" is done at the Chicago office. Mr. Jackson advises that there is every reason to believe that our income for 1947 will be materially higher than for 1946 and that as long as the present economic conditions last we may expect increases in income each year.

We wish to take this opportunity to thank Dr. Stanley Weld, Chairman of the Advisory Committee, for the "swell" job he has done and is now doing. He has spent a lot of time on this work and knows all its angles. And, too, Mr. Jackson comes in for some salvos. He came to us from the mechanical department of *The Journal of the American Medical Association*, and in a very short time had fitted into the job just right.

We feel that we know Stan Weld well enough to tell a little story about him, one that he himself told. Up until he became editor of the *Connecticut State Journal*, he never had been West; as he put it, he had never been West of the Hudson River. He had heard a lot about the cowhand and the Indiana of the western country and of course had read of the goings-on in Chicago, during the Volstead era. When he learned that one of his jobs was to attend the Secretaries-Editors Conference, in Chicago, he was quite perturbed about it—did not care to go out there where gangsters shot one another in the streets, and all that sort of thing.

Finally, he got his courage up and made the trip, landing in Chicago an hour or two before the time set for the first session. Got over to 535 North Dearborn, without mishap or having any bullets fired in his direction, registered, and sat himself down to see how things were done in these conferences.

Dr. Earl Wheedon, then Secretary of the Wyoming Society, was named as chairman of the meeting. Earl walked to the dais and from each hip pocket drew an old-time six-shooter, laid them on the desk before him and declared—"Let's get going and if anyone wants to start something, I am prepared!"

Poor Stan was fit to be tied; here was plain evidence that his fears had been well grounded. There was nothing he could do but sit tight and hope for the best. At the end of the two-day session Wheedon had not found it necessary to use his guns and Stan began to feel a bit better about it. However, he remarked that after his train had left the Chicago city limits he began to breathe much more comfortably.

The Co-Operative Medical Advertising Bureau is now in the control of the member journals, as it should be; there is an active advisory committee to direct its policies—this committee frequently seeking the advice of all interested journals. Our Director is intensely interested in his work and we predict that in another year or two he will have every detail moving along in tip-top fashion. From time to time we will give you the actual figures as to the amount of cash we receive, each year, as our part of the profits. We are advised by professional advertising people that our cost is far less than the average in this field and Mr. Jackson also advises that in all probability our costs will come down, rather than go up.

The Kaadts

At long last the Kaadt brothers, of South Whitley, long-time operators of a "Diabetic Cure" have "come to the end of their rope!" This via a hearing before the State Medical Board on charges preferred by the Indianapolis Better Business Bureau, in which the Bureau sought the revocation of the medical licenses of the two brothers.

As usually is the case when the Bureau enters into such hearings, their evidence was of the bullet-proof sort; they brought several former Kaadt patients all of whom told the same old story—of having heard of the prowess of the two brothers and then hying themselves to South Whitley, forthwith. And not the least of the many bits of convincing evidence was that of a reporter for the *Indianapolis Star* who, after competent medical examinations, was found to be in good health, certainly not a diabetic.

Robert Johnson, a staff writer for the *Star*, did not have to do any talking when he went in to register as a patient—the Kaadts had a woman on the job who knew how to handle such situations.

Like all other patients—we almost had said "suckers"—he was given a gallon bottle of "medicine," the analysis of which showed it to be vinegar, well fortified with saltpeter. The usual charge of $30 was made for this "home treatment," presumed to last a month.

During the hearing the younger brother, Charles F., and founder of the "Institute," had, through his attorneys, "thrown in the sponge," accepting revocation of his license, with prejudice. But the other half of the sketch went on to the finish, only to have the Board unanimously vote for revocation. Both of these men are over seventy years of age, according to records at hand. Peter graduated from Rush Medical College, in 1895, while Charles took his degree from the Keokuk, Iowa, school, in 1902.

These chaps surely made hay while the making was good; they had a patronage not only from Indiana but from all over the country. Some of these patients testified that the Kaadts had taken them off of insulin, used their own medicine, and that soon after the patient arrived home there was the inevitable coma. Some are said to have died soon after using the treatment.

It might be mentioned that in addition to the thirty-dollar-home-treatment package, the sucker

paid a fee of thirty dollars for the three-day stay with the Kaadts, thus it may be seen that the financial phases of the picture was indeed most satisfactory—to the Kaadts.

Albert Stump, who handled the prosecution, remarked in his final address to the Board, "Some diabetes sufferers could not be rescued quickly enough from the quackery of Doctor Kaadt, and deaths were the result."

Thus ends one of the most sordid chapters in the history of medical quackery in Indiana, a chapter that reeks with infamy, and worse. It furnishes further evidence that the mere licensing of an individual to practice the healing art is not enough; means should be—must be—provided for the enforcement of our medical laws. Practice, such as carried out by the Kaadts, should not be permitted to go on and on—they should be nipped at the start —before folk receive their death warrant. Just how this may be brought about cannot be foretold at this time, perhaps an annual registration fee, such as has been endorsed by our House of Delegates, will provide the necessary funds for a full-time investigator. Whatever the remedy may be, it is certain that some measures are needed to correct such flagrant abuses as were brought out in the hearing of the Kaadts. Then, too, there are many other "spots" to be investigated, many other illegal practices that are being carried on in our Hoosier State, all of which should be thoroughly investigated and the proper corrective measures taken.

We congratulate the Better Business Bureau for having been instrumental in ridding the medical profession of two such ingrates.

Editorial Notes

In the December number of the Bulletin of the Indiana State Board of Health, Dr. J. T. Oliphant, former president of the Indiana State Medical Association, presently a member of the Indiana State Board of Health, gives a résumé of diphtheria control in Sullivan County, his home. In one of his opening statements he says, "It is easy to forget that only ten years ago diphtheria toxoid was so absolutely new that its value in preventing epidemics had not been tested." He then goes on to say that in his county of 27,000 inhabitants the local medical profession began a campaign to eliminate this dread disease from within its borders. He sets forth the preliminary plans, as well as the actual carrying out of the program. Net results are that some 9,000 Sullivan county folk have had these shots. In the last ten years there have been reported *four* cases of diphtheria in Sullivan County, none of which had been immunized. He quaintly remarks, "Mild epidemics in neighboring counties failed to wash over into Sullivan County." This is but another instance of the value of a county-wide immunization program.

We overstepped ourselves a bit in getting out our Year Book, the largest JOURNAL we ever had published, so have had to retrench a bit in the matter of pages used. This will account for the small number of pages in the February number. It seems there still is a paper shortage and we are allotted just so much paper stock for the year, so that when we step out and do a big number we have to make up for it, later on.

Ringworm of the scalp, having reached epidemic proportions in many communities, has become a most acute problem. Elkhart is among the cities much affected, it seems, and recently a series of clinics were established for the treatment of this stubborn ailment. Doctor Schwartz, of the United States Public Health Service, spent some little time in that city, assisting in the clinic program and expressed himself as being very happy to note the interest manifested in the program.

Many of our Indiana newspapers are commenting on the six annual scholarships to be set up at the University Medical School by the Indiana State Medical Association. These papers are interested in the proposal that those accepting these scholarships will go into practice in the rural areas, at least for a stated time. *The Bloomington Star Courier* quaintly states, "The Association isn't going to be selfish about the matter—it will welcome the financial aid of any individual or firm wanting to add to the number of scholarships." This same paper also comments on the fact that some church organizations face the same problem—many of their young ministers do not care for rural pastorates and the organization has the feeling that if they are paying for the education of the young minister he should go where assigned.

Here it is, March; quite some spell before our annual meeting in French Lick, next October, yet not too early to think about reservations and the making of plans to attend this great meeting. October is our favorite month at Indiana's greatest resort—we have been there at all seasons and find October just about tops. Usually, the weather is just right, plenty of sun and little rain—maybe an evening or two when a top coat feels good. And, the fall Bibb lettuce season will be on—our favorite salad lettuce. (Incidentally, we recommend the planting of a few seeds of this delectable vegetable in the home garden—get it started early, just as soon as the ground can be worked; it will not stand hot weather.) We are tuning up for our one hundredth anniversary, these days, so get in line with a thousand or more other members and get all set for the Big Celebration. Let's all go to French Lick!

The Indiana Medical Year Book evidently has made a big hit; we have had many communications regarding it, and one organization was so enthusiastic about it that its executive secretary wired us to the effect that it was the "biggest and best" thing of the sort he ever had seen. We have had numerous orders for extra copies, also. We hope to make this an annual feature, changing, of course, much of the material and adding other features. Naturally the expense of such a large volume was quite an item, but, thanks to Ray Smith, we carried $1,028 in extra advertising, the cost of which amounted to $37 to cover printing and postage. We again urge members to preserve this magazine—better keep it at your right hand—it has a lot of worth-while information.

Among the many interesting features of the centennial celebration of the founding of the American Medical Association, to be held in Atlantic City, June 9-13, will be a banquet for the leaders in industries and occupations associated with Medicine. Also, on Sunday, June 8, a religious service will be held in the "great hall," with three outstanding leaders of three great religions, Catholic, Protestant and Jewish. Monsignor Fulton J. Shean, of the Catholic University, in Washington, Rabbi Joshua Liebman, of Boston, and Dr. Ralph Cooper Hutchinson, president of Lafayette College, Easton, Pennsylvania, will represent these churches. The topic to be discussed will be "The Spiritual Aspects of Medicine and Health." While this program is going on ministers throughout the nation will be asked to devote their sermons on that date to the same subject.

"——— cigarettes are the preferred brand of the average doctor," says an advertisement currently appearing in many lay magazines and newspapers; "20,000 doctors say ——— cigarettes are kind to the throat," says another advertisement—this statement often appearing in the "plug" for a brand of cigarettes, via the radio. Then along comes the statement that a certain brand of soap is preferred by so many thousands of our profession, which leads us to remember that not long ago one of the "throw-away" magazines circularized the profession on this subject, asking them to name the soap they thought preferable for babies. Evidently a large number responded, affording this screed sheet to sell the idea to a soap manufacturer. Now comes another soap inquiry, from still another of the "free" magazines — wanting to know what soap *we* prefer for this or that purpose. Had we obeyed our first instinct we would have answered, stating that good, old-fashioned, soft soap, as made in the back yard down in Wild Cat, is our preferred brand; on second thought, we took our usual stand in such matters and did not reply. How long will the medical profession fall for this sort of guff!

Have you paid your 1947 dues? That is the big question with headquarters folk. As we repeatedly have said, prompt payment of dues saves us a lot of work. We do not especially need this money, right this minute, but if it comes in on time the transaction can be handled promptly, without interfering with other office routine. Then, too, it is well to remember that certain advantages are yours for the payment of dues, on time. Your medical defense, for one thing; the association cannot assist in such a defense if one has not paid his dues at the time the services complained of were rendered. Better check and see if you have your 1947 card.

The Goshen News-Democrat facetiously comments on two items that recently have gone the rounds of the press; one to the effect that "gum chewing is saving thousands of people from losing their hearing, due to the common cold." The other refers to the recommendation of a United States Public Health Service dentist that the proper time to clean the teeth is right after meals. The Goshen editor agrees with both these recommendations; says gum chewing, in public or in private, is all right with him, while the use of the post-prandial toothpick fits in nicely with his ideas. Wonder if the gold toothpick, the one that we hung onto the end of our watch chain, might be on the way back!

A few years ago one of the largest pharmaceutical companies of the South got out a sulfa preparation for the treatment of gonorrhea. There were some four-score deaths among those who purchased this "dope" at the drug stores. It developed that the company, without laboratory investigation, used a "solvent" that was lethal in character. It is said this error cost the company a half-million dollars and resulted in the suicide of its head. Now comes another news story, this time concerning beer. It seems that due to a shortage of starches that several breweries, most of them in Chicago, began using an imported article to replace the starch content. This resulted in the beer being a bit cloudy. The story goes that a drug company salesman recommended the use of mono-chloracetic acid to "clear up" the beer. Apparently it did and the beer was out on the market. However, in due time, the Federal Food and Drug Administration began an investigation and condemned almost two million bottles of the product, which promptly was poured into the sewer, creating a considerable loss to the several breweries concerned. Just how long we will countenance acts of this sort, the use of drugs for this or that purpose, without due investigation we do not know, but it is all too common to read that this very thing is being done. Mono-chloracetic acid is a lethal drug and although the amount to be found in a single bottle of beer would not cause death, there are those who are not content with *one* bottle, they want a case or two! Verily, we still need some additions to our Food and Drug laws!

The annual compilation of deaths in the profession is published in the January 11 number of *The Journal of the American Medical Association.* The total number of deaths of physicians in 1946, as given in the compilation, was 3,558. The average age at death seems to have increased, the figure for 1946 being 66.1, as compared with 65.3 for 1946. The dominant age group was 70-74. Heart disease, with coronary thrombosis, continues to lead as a cause of death among our profession, coronary disease accounting for 738 deaths, a substantial increase over the preceding year. There was a decided stepup in suicides; for 1945 the figure was 25, for 1946, 55. There were 130 accidental deaths, of which 55 involved automobiles. One physician died in a recent Chicago hotel fire. Forty were killed while in action, as members of the military forces of the United States, while 128 others died while in military service, 19 of these from coronary thrombosis. The total compilation of medical men who died in service during the entire war period is recorded as being 257 killed in action, 501 who died while in military service.

On various occasions we have commented on the dates set for some of our conference meetings, there having been considerable criticism, at times, of the inconvenience occasioned by such settings. For many years the annual Secretaries Conference was held in March and, on several occasions, weather conditions were such that the attendance was materially limited. It was then suggested that these meetings be held later, say in April, but nothing was done about it. November through February is the time set for several meetings, both local and national in character. Among others, we have the Secretaries-Editors Conference, usually in November, this past year early in December. Then comes the extra session of the House of Delegates of the A.M.A. Several other meetings are set for this period by the American Medical Association. In January and February we also have a number of such conferences, which call for attendance on the part of many of the Indiana group. This year we have the mid-winter session of the Council and the Secretaries Conference in January. This is inconvenient, for numerous reasons, say many of our members; they already have several commitments at this time, then weather conditions also are to be considered. Had these two meetings been set a week ahead this year, it is very probable that the attendance would have been extremely limited, due to road conditions. As we write this we are advised by the Indiana State Highway Commission to put the car in the garage and keep it there, using it only for emergencies. We are quite agreed with the many members who suggest that this Conference be held later in the year, April being a very suitable time. This will not "pile up" the winter meetings to such an extent as now prevails and certainly we may expect much better weather conditions.

"Cigarette fires" seem to be on the increase, many of the all too frequent hotel fires having been traced to this origin. Down in the Capitol City, it seems, the City Fathers have taken a strong stand in the matter and have passed an ordinance prohibiting the smoking of cigarettes, et cetera, in many places, including department stores and hotel beds. This gives rise to a pretty problem—are hospital beds included in the order? The average citizen is addicted to some sort of smoking, and to lie in a hospital bed for several days, sans smoking equipment, is an intolerable thing to most of these folk. Thus this becomes but another problem to the hospital managements in Indianapolis.

Interest in the control of heart disease is currently being enhanced by the efforts of many professional and lay groups. This attention to heart ailments has long been warranted. The public is becoming more acutely aware of cardiac hygiene than ever before—a growing interest that should be cultivated and guided with judgment as well as vigor. During the past third of a century the improvement in mortality from heart disease was most pronounced in the younger age groups and decreased progressively with advance in age. The death rate from diseases of the heart and arteries, corrected for the ageing of the population, dropped virtually 30 per cent between 1911-15 and 1940-44, according to experience among the Industrial policyholders of the Metropolitan Life Insurance Company. This reduction in mortality from the principal cardiovascular-renal diseases has been particularly marked among white females—37 per cent in the above-mentioned period. Among the males the decrease in mortality, while not as marked as among the females, was 25 per cent, still a quite substantial reduction. This still leaves much to be desired in the field of early diagnosis and immediate initiation of adequate cardiac regimes in order to reduce to a minimum incapacity and mortality from these conditions. Concentration of effort must now be placed on teaching the public what is known about prevention, early recognition, and care of cardiac lesions. In order to assist in the attainment of this goal, the Metropolitan Life Insurance Company is conducting a special campaign on heart disease during the fall and winter months. At that time, the company's more than 20,000 field representatives, in cooperation with official and voluntary agencies, will reach the homes of millions of policyholders with a recently published pamphlet, *Your Heart*, developed in cooperation with the American Heart Association. A lay educational film on heart disease is also being prepared. Distribution will be made to physicians of a packet in which will be included material of special interest to doctors, and a scientific exhibit on heart disease, first shown at the A.M.A. meeting in San Francisco, is available for state and local professional meetings.

President's Page

WHY HAVE A COUNTY SOCIETY?

No, the question is not asked in fribbling levity. Just casual analysis or even superficial scrutiny would disclose elements of real substance.

As of this writing, the dues-paying membership of our association is 3,505. Not everyone, nor is it pressingly essential, is called to service at the state level in any one year; roughly, 6 per cent are so engaged, and the individual personnel changes from time to time, and rightly so.

However, at the county society level 100 per cent activity and interest can and should be maintained, yet a state-wide survey shows an average of half or less. Wherein lies the fault?

Unused muscles atrophy and decay. Our bodily vigor depends upon the proper exercise of our muscular structure. The county societies are the muscles of our state association. Over the quite recent years slick-paper magazine writers frequently stress that everyone loves the physician as an individual, but they delight in taking "haymakers" at us as a group. Why? What is wrong with us? Surely we're smart! We're well trained! Collectively, the best in the world! We practice good medicine. Think!

ORGANIZATION at the county level is the answer.

The well-ORGANIZED county society is the custodian of all phases of medical care in its own community. It polices and disciplines its membership. It is active in press and radio publicity and maintains live contact in its public relations with all civic affairs related to the public weal. It controls all phases of medical practice in its county and all professional services in its hospitals. It's members are beyond reproach in their ethical conduct. Its fee schedules are adequate, yet just. No one in its entire area suffers from a lack of good and proper medical and surgical attendance. Its elective representative in the state general assembly is favorably impressed by, and is reasonably inclined toward, our profession as a whole as well as to any particular individual. Its members walk proudly among their fellowmen, heads up, eyes forward, chests out, lithely and strongly.

Truly, there is ample opportunity for 100 per cent activity in every county society of this great state, Indiana; and these are just a few random thoughts of a rocking-chair philosopher, as he ponders the past and envisions the future of our now ninety-eight-year-old, great Indiana State Medical Association.

Floyd L. Romberger

INDIANA'S THIRD INDUSTRIAL HEALTH CONFERENCE

AUDITORIUM, INDIANA UNIVERSITY SCHOOL OF MEDICINE

APRIL 16, 1947

INDIANAPOLIS

Sponsored by: Indiana State Medical Association,
Committee on Industrial Health,

Indiana University School of Medicine,
Department of Public Health,

and

Indiana State Board of Health,
Division Industrial Hygiene.

MORNING SESSION

Presiding: JOHN VAN NUYS, M.D., Executive Secretary, Indiana University School of Medicine.

8:30- 9:30 Registration.

9:30-10:00 Opening Remarks. E. S. JONES, M.D., Chairman Committee on Industrial Health, Indiana State Medical Association; and T. B. RICE, M.D., Professor of Bacteriology and Public Health.

10:00-10:30 *Indiana Workmen's Compensation Laws.* Mr. JOE MILLER, Chairman, Indiana State Industrial Board.

10:30-11:15 *Disability Evaluation.* HENRY H. KESSLER, M.D., Member of the Council on Industrial Health, American Medical Association, Newark, New Jersey.

11:15-12:00 *Industrial Diseases of the Chest.* L. E. HAMLIN, M.D., Medical Director, American Brake Shoe Company, Chicago.

Lunch—Riley Hospital Cafeteria.

AFTERNOON SESSION

Presiding: L. E. BURNEY, M.D., Secretary, Indiana State Board of Health.

2:00- 2:45 *Industrial Dermatoses.* L. F. WEBER, M.D., Associate Professor Dermatology, University of Illinois College of Medicine, Chicago.

2:45- 3:30 *Toxicology of Heavy Metals.* DOCTOR LAWRENCE FAIRHALL, U. S. Public Health Service, Washington, D. C.

3:30- 4:15 *Control of Upper Respiratory Diseases.* DOCTOR ANN BAETJER, Assistant Professor Physiological Hygiene, Johns Hopkins University, Baltimore, Maryland.

4:15- 4:45 Discussion of Papers.

The Committee on Industrial Health, as part of its planned program to develop post-graduate training in industrial medicine, is sponsoring the Third Industrial Health Conference at Indianapolis on April 16. During the past two years such meetings were cancelled; however, now that conditions are assuming normal proportions it is the committee's aim to have such meetings every year.

It has been the policy of the committee to have nationally known speakers participate in the program. This year's program emphasizes that point, for each of the speakers is a national authority in his or her field.

The meeting is a one day meeting open to physicians, personnel directors or safety directors. There are no registration fees.

A STORY ABOUT MILK

F. R. NICHOLAS CARTER, M.D.

HEALTH OFFICER

SOUTH BEND

A SIMPLE story is told about two families that lived across the road from each other at the turn of the present century. One obtained its milk supply from a faithful old Jersey cow. The other obtained its milk from a small herd of Guernsey cattle. Both families boasted about the richness of their milk and the thickness of their cream. Since milk is an excellent food, both families were generous in their use of milk and milk products.

In every way, except one, the children of the two families were much alike. The similar clothes which they wore were purchased in the same little village department store. The books they studied in school were exactly alike. The dinner pails they carried to school were the same. In only one way were the children different.

Whereas the children of the first farmer were strong and healthy, with rosy cheeks and boundless energy, the children of the second farmer were anemic and emaciated and suffered from marked debility.

At no time were the children of the second farmer entirely free from the foul-smelling, pus-discharging sores under their lower jaws. All during their school days it was necessary for them to wear protective bandages, and these would soon become saturated with the malodorous discharge. Other children would refuse to play with them. It was whispered in the community that they had "bad blood" and should be avoided. This whispering occurred even in the face of the fact that the family doctor said that the condition was known as scrofula, and it was a very old disease whose cause was unknown.

Analyzed in the light of present-day knowledge, we know that the herd of cattle from which the second farmer obtained his milk was infected with the bovine type of tuberculosis. More than this we know this milk was the source from which his unfortunate children acquired their ugly, sickening infection. Reasoning from the same viewpoint, on the other hand, it seems logical to think that the milk supply of the first farmer was not contaminated with tuberculosis since his children were healthy and free from disease. It goes without argument to say that had the farmer who owned the diseased cattle known of their disease he would have disposed of them immediately. But he did not know this, so he retained the herd and used the milk and thereby continued to shower his family with repeated deluges of the disease-producing germs and his children continued to suffer with the ugly, chronic sores that made them into social outcasts.

Nor does the story end at this point. A mile distant from the two farms there was a small community of families. Since automobiles had not yet pervaded the quiet of the little hamlet there was no sign to say that the little town consisted of two thousand population. A town of two thousand population needs milk, the same as a town of a hundred thousand population, and an enterprising citizen of the little town knew this.

He conceived the idea of organizing a dairy. He visited the first farmer and contracted with him to take his surplus supply of milk. Likewise, he visited the second farmer and many other farmers and contracted with them to take their surplus. Gradually he obtained a sizable amount of milk to distribute to the little village. Every morning he collected the milk from the various farms in a large tank. First on his route was the farmer whose children were healthy. The milk from his cow, which was not diseased, was poured into a tank. If we assume that the tank was clean and free from disease before it came to this farm we may continue to feel that the milk which was poured into this tank was still free from disease and safe to use. But let us follow this man in his collection of milk. His second stop was at the farm of the man whose children were diseased. At this farm the milk from the tuberculous-contaminated herd was poured into the tank, along with the disease-free milk from the first farm. Now there was no disease-free milk and, regardless of how many farms it was collected from, as it was put into the common receiving tank it was contaminated with tuberculosis. The end of the story was simply that the ugly sores of the farmer's children were spread throughout the little town and there produced the same cruel disaster in the lives of other victims.

Thus a simple story has been related to show how easily milk which is free from disease can be contaminated. It also illustrates how contaminated milk may spread disease to an entire community.

Almost a half century has passed since the events in this story took place. Today we know that scrofula is caused by the bovine type of tuberculosis. We know that herds of cattle can be tested to find the infected animals. Once found they can be eliminated from the herd. The result of this procedure is the almost complete eradication of the bovine type of tuberculosis in human beings.

The question arises, who is to assume the responsibility of seeing that the herds are tested for tuberculosis. Since milk is collected from farms and is used in large amounts in cities it therefore

becomes the obligation of local government units to set up rules and regulations governing its production and sale. Naturally one of these rules would require that all cattle be free from tuberculosis. However, it is just as important that milk be free from other diseases, such as typhoid and undulant fever, diphtheria and streptococcal infection. One hundred per cent pasteurization is the only method by which we can achieve the elimination of these infectious conditions, and there must be constant and intelligent supervision of the pasteurization process. The word "pasteurized" printed on the milk bottle cap does not necessarily mean that the milk inside the bottle is pasteurized.

Just what rules and regulations should be adopted and subsequently enforced is usually left to the local health officer to determine. The state of Indiana requires that a local health officer be a doctor of medicine, well trained in sanitary science. At the present time there are 191 health provinces in Indiana and 191 doctors of medicine who preside over these local health units. While all of these doctors have had training in the general science of bateriology, it is doubtful if any of them have had sufficient training in the highly specialized science of milk inspection. Therefore, from a purely scientific viewpoint, it is doubtful if any one of these doctors could write a satisfactory ordinance covering the very important task of milk inspection.

Again, from a legal viewpoint, a local health officer faces a very different problem in the creation of a milk ordinance. Hours may be spent by him in writing a milk ordinance and an equal amount of effort expended by the City Council in mulling over its contents before it is finally passed and ready for the final signature of the Mayor. All of this may be done and the ordinance be absolutely worthless if it is not enforceable. A good milk ordinance must have teeth in it if it is to be useful to the health officer in milk inspection enforcement.

Assuming then that the local health officers of the present day have neither the scientific training necessary to write a satisfactory milk ordinance nor the legal knowledge of how such an ordinance can be so written that it will be enforceable, what then can be done to secure a good milk ordinance in our various Indiana towns and cities?

Apparently the United States Public Health Service has realized the difficult position in which a local health officer is placed when it is necessary for him to assume the serious responsibility of inspecting the milk which his city consumes. They have therefore come to his aid by creating a model ordinance which he may follow. In order to make an ordinance which would be scientifically sound and legally enforceable the United States Public Health Service, at an early date, called together some of the best minds in the field of milk production. These men came from the milk industry as well as from the faculties of our great universities. In addition to these well-trained men, there were outstanding health authorities in this group. Certainly this combination of talent was infinitely more capable of writing a satisfactory milk ordinance than any local health officer, who had only meager training in the highly specialized field of milk inspection.

The ordinance created by this group has been called the United States Public Health Service Milk Ordinance and Code. At the present time there are more than 2,400 American cities which have adopted this standard ordinance as their method of milk inspection. It has withstood legal attacks from the east to the west coast. It is an enforceable set of rules and regulations that are as easily read by the farmer or the dairy as by the health officer. When the ordinance is adopted by a city an explanatory code is also adopted. This code explains the public health reason for the rule. It also explains when a farm or a dairy has given sufficient compliance with this rule or regulation. Here then is an ordinance which is scientifically sound and enforceable from a legal viewpoint. Any community adopting it may rest assured that it has placed into the hands of its health officer an up-to-date and efficient ordinance with which he can perform his serious duty of milk inspection.

An explanation of the Grade A ordinance would be incomplete if one failed to mention that the state is constantly rendering consultative service to the local health officer to help in its enforcement. Not only the state renders this service but the United States Public Health Service renders a like service. A review of the ordinance by the United States Public Health Service occurs every five years. If changes in the field of milk production or milk processing or sale have occurred, then the United States Public Health Service suggests that amendments to the local ordinances be made to accommodate these changes.

Milk inspection has become greatly improved in those Indiana cities which have adopted this standard Grade A ordinance. There are still many towns in the state which have no ordinance or which follow an ordinance written by present or past health officers. It is doubtful if any of these ordinances are efficient or enforceable and when one contemplates the seriousness of milk inspection, and the obligation it places on the health officer, he wonders how such inspection can continue to exist.

Therefore the solution to the problem of satisfactory and uniform milk inspection in the state seems to be the adoption of the standard Grade A ordinance.

A.M.A. CENTENNIAL CELEBRATION
June 9-13, 1947—Atlantic City
HAVE YOU MADE YOUR RESERVATIONS?

OBSERVATIONS OF A GENERAL PRACTITIONER

H. G. WEISS, M. D.

EVANSVILLE

THE general medical practitioners of the nation, and especially those of the State of Indiana, are very proud of the recognition and laudation they have been receiving during the past year from the medical profession, and of the honor of having a section at the American Medical Association, at San Francisco, this past summer. Their appreciation was shown by a splendid program, a good attendance and the interest manifested in the program, as well as in the "bull-sessions" during the intervals.

In many quarters, we hear the expression that the men in general practice, are the "backbone of the profession," that they are the mortar between the stones that bind together the specialties, or parts that form the structure of the profession. A scrutiny of the general practitioners as a group conveys the impression that the term mortar is appropriately applied, for they are indeed a conglomerate, indescribable group that has within its ranks some of our best medical minds, progressive, alert, and in knowledge and ability the equal of any specialist, as well as many of the mediocre class that has made little or no progress since graduation from college. The great preponderance of this latter class has lost for the general practitioner much of the confidence, respect and prestige among the profession and the laity, to which he is entitled.

It is only too true that some men in general practice are in that class, because after graduation and required internship they were content to rest upon their laurels and practice their profession, for it is the easy way and requires less effort than to specialize. These are the men who do not consider it worth-while to pursue postgraduate studies, and one seldom sees them attending a scientific meeting, or ever taking an active part in its programs. As a result, they are not able to keep abreast of professional progress and thereby lose the respect and confidence of the profession and the public, as individuals and as general practitioners as a group. But there are also physicians who are in general practice because they enjoy the inclusiveness of a general practice, its breadth, fully realizing that to be a good general practitioner, with all that it implies, requires more knowledge and skill and hard work than a specialty. They are in general practice because it gives them a limitless field where they may expend every resource and energy they may be able to muster, and because they enjoy the intimate and enduring relationship it establishes between them and their patients in their role as family physician. Such physicians are so interested in their work that it drives them to a continuation of their studies and one generally finds them keeping pace with the specialist, often with a broader and more comprehensive knowledge of medical progress.

It has been generally recognized that only the general practitioner can fill the much-lauded position of family physician, for it is he who comes into continuous contact with the different members of the family. He, more than any other person, knows their abilities and resources—physical, mental, spiritual, social and economic—and is able to understand, to interpret, and even to anticipate their reactions under the varied circumstances and phases of life.

To be successful as a family physician requires not only knowledge of the human body and its diseases, but a knowledge of psychology, an understanding of family life, of family relations, and the family's relation to the social and economic life of the community and the nation.

From many quarters we have heard, of late, the complaint that too many of our young graduates are taking up specialties, that thereby the ranks of the general practitioners are becoming depleted, and that with it there is a passing of the family physician. This movement on the part of our young graduates should not be deplored, but recognized and commended as a healthy sign of progress and vitality in the profession. It demonstrates a desire in our young graduates for more knowledge and greater ability than that required for an M.D. degree.

It often has been stated that graduation in medicine and a license to practice is sufficient, and that the various boards are superfluous. That this statement is not true is demonstrated by recent experiences, for we find our graduates desire more training, that the public is "specialist-conscious," and that our hospital staffs and courts recognize the superior qualifications of the diplomates of the boards.

If the practice of general medicine, or the role of family physician, as such, wishes to attract our recent graduates, and maintain its standing in the profession and with the public, in self-defense it must follow suit with some form of organization with higher standards in their line of work than those required by our medical colleges for an M.D. degree, and some method of recognition of this superior qualification.

The officers and members of the Indiana State Medical Association are to be congratulated for being in the vanguard in forming such an organization, in establishing the "Indiana Board of General Practice of Medicine." Similar boards are being organized in several of the states and it is to be hoped that the several organizations may be able to unite and form a national board.

It is the ambition of these boards not only to require evidence of certain qualifications for admission, but to encourage or compel a certain progress after admission, and it is hoped that a workable plan may be evolved for such progress and recognition of its attainment. This is a movement which every alert, progressive general practitioner should welcome with delight, a movement which he should support to the fullest extent of his ability, for his own interest, for the interest of the profession, and in the interest of his patients.

A paragraph written by Dr. Morris Fishbein on medical ethics, published in the November issue of the *Journal of the American Medical Association*, has come to the writer's attention, which may appropriately be repeated in this paper. "The Principles of Ethics" recognize that medical diagnosis is usually paid for insufficiently in comparison with the rewards of surgical technic. "The patient should be made to realize," say "the Principles of Ethics," "that a proper fee should be paid the family physician for the service he renders in determining the surgical or medical treatment suited to the condition, and in advising concerning those best qualified to render any special service that may be required by the patient."

While the men in our specialties are praising and extolling the worth and virtues of the general practitioner, or the family doctor, they should also recognize the foregoing statement, and consider dividing equitably with him the financial emoluments that accrue in treating the sick. We all are aware that in too many instances the family physician is called to attend a patient, he visits him, often in the wee hours of the morning, he examines him and racks his brain to make a diagnosis. As the case progresses he or the family may come to the conclusion that a specialist in the field into which the case has drifted should be consulted, or that a special surgeon should be called to perform an operation. The family physician delivers all data collected, renders all possible assistance to the specialist for a better understanding of the case, and steps into the background. During all of this time the family is distressed and the sympathetic family physician and friend does not have the temerity to mention a fee, much less to collect it. The specialist renders the required service and generally collects for it. He is usually a stranger and is not asked for credit, even if it takes the last dollar of savings, or a mortgage on property, to balance his account. After the specialist completes his work, if it is successful, the patient is returned to his physician for treatment during a period of convalescence. If the treatment is not successful he often is blamed for the choice of his assistant. Too often, in making his charges, the specialist does not take into consideration the patient's ability to pay his fee, the hospital bill, and a commensurate sum for the payment of the family physician. To salve his conscience, and to out-bid his competitor, he often offers the family physician a part of the money he has collected. The family physician, realizing that he will not be paid for the time and effort expended, accepts the gratuity (feeling as proud as a family pet that picks up crumbs from the master's table), and considers himself obligated to send that specialist his next patient.

Whenever the specialist discards his superiority complex and regards the family physician as his equal, and makes his charges accordingly; when the general practitioner qualifies as modern and efficient, recognizes his efficiency, and develops sufficient professional pride and "backbone" to charge a fee commensurate with his services and collects the same, the much decried, nefarious practice of fee-splitting will die of inanition.

If the position or institution of the general practitioner of medicine, or family physician, is of value and worthy of perpetuation, and we wish to retain within its ranks some of the better men of the profession, this movement for a National Board of the General Practice of Medicine merits the support of every group in organized medicine.

VOICE OF MEDICINE

CAN YOU TOP THIS?

I began practicing medicine the 28th day of March, 1898, in Clay City, Indiana.

On the 16th day of March, 1899, I delivered Mrs. Blank of a baby girl, named Tressie. Her father went in the Spanish American War and the family moved away from Clay City without paying for her delivery.

At that time the minimum fee was $5.00 and the maximum fee was $10.00. Her fee was $10.00.

Last fall Mr. Blank's estate was settled and at that time Mrs. Tressie Blank learned that the service for her delivery had not been paid. She called me by long distance phone from Indianapolis, and asked to pay for her own delivery, which was $10.00, but she wanted to add $5.00 for my patiently waiting. She paid it January 8, 1947, making her age 47 years, 9 months and 22 days.

One other has paid for her own delivery, at the age of 39. My tabulated number of deliveries at present is 6,241.

H. R. Vandivier, M.D.,
210 Rose Dispensory Bldg.,
Terre Haute, Indiana.

WHO WANTS MEDICAL SOCIALISM?*

An answer by the medical profession to Mr Paul Feltus, Editor, Bloomington Star-Courier

RECENTLY, there have appeared in the editorial columns of the Star-Courier arguments for the establishment of compulsory universal socialized medicine à la the Wagner-Murray-Dingell Bill and like legislative efforts. The editor, upon being taken to task by a medical friend for these published views, stated that if a suitable reply were to be prepared he would publish it in the same columns. Here is the reply.

On behalf of the regular medical profession of this city and county, and for the good of the public and the future progress of medical science, the following statement has been prepared in direct reply to the statements made in the editorials hereby objected to:

1. The **Christian Science Monitor** notes hearings on the Wagner-Murray-Dingell bill "have been so staged as to ignore costs." Dr. Lowell S. Goins, former President of the California Medical Association, has brought out that "The costs of such a program would be stupendous and wholly unpredictable." Dr. Goins' writing in Medical Economics has emphasized the following arguments.

2. The existence of a need for it has been established more by emotional statements than by logic and documented facts.

3. Even if the need were soundly established there is no experience to indicate that compulsory health insurance would benefit public health although there is some reason to believe that it would lower health standards.

4. Medical care is not the sole factor involved in good health, and there are many things that could properly be done to benefit the public health before we embark on a program such as is proposed.

5. Voluntary health plans are more in keeping with the American tradition, and will result in far better care being given to our people.

Dr. Goins brings out the following points relating to each of the above numbered points.

"1. Cost—When (general) compulsory health insurance was proposed in California, no one appeared with any sound idea as to its cost. The guesses varied between $20 and $80 per person per year. Most thought that $40 was a fair figure. I think it significant that costs are nowhere discussed in the present bill, the Surgeon General of the Public Health Service being given a blank check. At $40 per person per year the program would cost $4,000,000,000 and no one really knows whether even this would suffice.

"Experience elsewhere indicates that there is needed at least one employee (not including those actually delivering medical service) for each 100 insured persons. On this basis we would need to increase the government payroll by about one and a half million employees. And yet, to pay this vast army, to pay the doctors, to pay for hospitalization and for the other benefits offered, no sums are named, no appropriations made, and no limits are set. This is a rich country, but no wealth is unlimited.

"2. Even if we had thoroughly established the need for some better plan for medical care, it would be proper to inquire whether a proposed plan offered some reasonable probability of improving public health. Since compulsory health insurance has existed in various parts of the world for fairly long periods of time, it should be possible to examine the experience in those areas and, by analogy, establish the probable effect of our plans.

"Compulsory health insurance has been in effect in San Francisco for some years as regards the municipal employees. The insured are served by the same physicians and in the same hospitals as are non-insured persons. In spite of the fact that no financial barrier exists between an insured person and a physician, the incidence of ruptured appendix is higher among the insured than among the uninsured. In this instance at least, the removal of the financial barrier, so abhorred of the social planner, did not seem to benefit the insured public.

"3. A sort of current custom is to use the terms 'medical care' and 'health' as if they were interchangeable, as though one were a synonym of the other. As a matter of fact, medical care is only a small part of the health problem, not even the most important part. Health consists largely in not being sick; medical care consists largely in an attempt to cure or alleviate disease.

"All, or at least most of the health legislation that has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Or, if in consultation with physicians, they were of the group who had little practical back-ground in actual practice. Consequently, nearly all of it contains much wishful thinking and not too much reality. Too much confidence is placed in preventive medicine, in the belief that periodic health examinations will prevent disease. The legislation evidences a complete failure to understand that preventive medicine simply has not attained the goals wished for.

"To cite a very few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination

* Published in Bloomington Star-Courier, Bloomington, Indiana, of October 11, 1946.

will be efficient in its control? How shall we prevent, or even recognize, early brain tumors? Shall everyone with a headache have encephalographic or ventriculographic studies? (Long, difficult, and tedious procedures as far as the patient is concerned). Shall we do gastro-intestinal x-ray studies on every one with indigestion and, if so, where shall be obtained the skilled personnel? How are some tumors prevented, and what periodic examination makes one aware of the pneumonia of next week? Preventive medicine cannot prevent tumors of female organs, breasts, stomachs, prostate glands, testes, etc. Medical care is, and will for a long period of time continue to be the care of the sick; and this I repeat is only a fraction of the health problem. Some other factions to which government might well turn its attention are: sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, working conditions, patent medicine control, and many others.

"If the government is sincerely interested in the health of the citizen why should it not regulate the cults, and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins and the like? This current legislation is attacking only a small segment of the health problem. Even if it were to accomplish all that its proponents claim, it still would not solve our health problems.

"4. Voluntary health plans will, if given the opportunity, do the job, and do it better than government controlled plans. These plans, which already include a very large number of persons, are in accord with our tradition of emphasis on personal responsibility, prudence, foresight and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to government controlled medicine." Government controlled medicine will always be political medicine.

California has made a good start in their California Physicians Service which offers medical care at modest cost. "A quarter of a million of our people have availed themselves of it and appear to be quite satisfied with it. The Farm Security Agency had a medical care program for the rural indigent. CPS took it over and gave better medical care for less money, and to the satisfaction of those giving and receiving the care." CPS has signed a contract with the State Grange, providing medical care for nearly 100,000 farm people.

"These activities are indications of how voluntary plans can meet the challenge, how they are meeting it, and how they will continue to do so with a steady and healthy growth, if they are not crushed by the monster of bureaucratic control."

The Indiana doctor's plan has been fashioned (after much consideration) after the various voluntary plans now in successful operation to attempt to adapt to Indiana people's needs the features of the other plans that will best serve them. Many of these plans have had to alter their program or curtail the benefits offered, or increase the rates charged, after they have been put in operation. The Indiana plan attempts to start with the rendering of service on a proven, workable basis at the start, and if the actual and operating experience is favorable to increase the benefits later. That is vastly better than starting to provide more than has proven practicable in other plans and then have to curtail the service offered! There are very few people who cannot afford an occasional small office call, examination, or minor illness, but the large items are the ones which upset their economic structure. For those who are unable the township trustees and welfare agencies have already made provision in our state.

At present the national scene is marked by uncertainty and drifting, in local policies, national policies, and many international ones. Washington is full of officeholders, at the public expense, many of whom are in bureaus whose authority overlaps others or which do things authorized by executive degree rather than by congressional law and constitutional direction. With the national debt what it is, and inflation already here, it would appear that a heartless lopping-off of employees, and bureaus, and unnecessary or duplicated services would be in order rather than to add further confusion by creating such another bureau as this would have to be.

Recent surveys have shown that the farmers of the country do not want such a legislation. "The leftists, shifters, and ne'er-do-wells, who hope to live off Federal handouts, will be found chiefly in the cities. They favor the measure which would force every citizen to shoulder a heavy financial burden to provide free medical care and free 'vacations' in hospitals. If the Wagner-Murray-Dingell bill becomes a law this nation will take a disastrous plunge into socialism. The back-breaking burden of building hospitals over the land and paying for free treatment of everybody by politically dominated doctors, would sound the knell of a free America."

New Zealand is admittedly one of the most socialistically inclined countries at present and they have found their disability pensions and medical care benefits tripled between 1940 and 1945. Hospitalization, medical care, and pharmaceutical and supplementary medical benefits have shown substantial increases every year since the inception of their compulsory health insurance scheme. The reasons are: first, largely the human tendency to take advantage of benefits offered under a compulsory system; and secondly, the political pressure for increases in rates and duration of benefits as well as for increase in coverage. New Zealand has had this system since 1939. Its cost has increased

steadily. Now they are seriously considering abandoning it. Truly the 'gimmies' have shown their effect there.

Medicine and politics are not good companions. Under political domination the doctor is, either directly or indirectly, told what he can and may do or not do. This prejudices his medical judgment and often is not to the best interests of his patients. He must please those higher in the system or his career is ruined. Therefore, instead of being primarily a doctor, whose first interest is the good results he can secure for his patients, he becomes a political office-holder. This lessens the attractiveness of medicine as a career for it only leads to federal office-holding in 'the system,' with the red tape and stifling of initiative that always occurs under such circumstances. Thus, instead of having doctors who have studied medicine because it is their primary interest we develop a lot of political office-holders with M.D. degrees. Thus, medical research and advance becomes slower and less productive. Our American way of life has shown the way for the world and our medicine is second to none, so why should we copy the systems of Communist Russia, and the mentally, morally, and politically decrepit and bankrupt countries of Europe?

Enactment of such measures is desired by certain elements of our country. These elements are: (1) Communists; (2) Impractical and ill-advised, although perhaps well-intentioned, dreamers, 'do-gooders,' and theorists; (3) Ne'er-do-wells and loafers; (4) Bureaucrats desiring to make more political jobs for more voters to help keep themselves in office regardless of whether the jobs are necessary or helpful, or whether the end result will be for the permanent good of the country or not. In order to accomplish these aims, facts have been misrepresented or the hearings have been allowed to produce only items favorable to their views and avowed aims.

Mr. Feltus, we hope the above statements will serve to explain our position and our view. There is no personal antagonism involved or party politics, merely the knowledge, experience, and facts which explain why the medical profession is bitterly opposed to the Wagner-Murray-Dingell bill and like compulsory and ill-advised legislation.

Signed: *Owen-Monroe County Medical Society.*

Indiana State Board of Health

Division of Communicable Disease Control

Monthly Report—October, 1946

Diseases	Oct. 1946	Sept. 1946	Aug. 1946	Oct. 1945	Oct. 1944
Chickenpox	141	35	21	82	90
Measles	26	16	22	17	13
Scarlet Fever	200	87	63	217	137
Smallpox	1	0	0	1	2
Typhoid Fever	21	9	11	6	11
Whooping Cough	61	88	100	113	42
Diphtheria	48	18	18	55	40
Influenza	18	10	2	26	9
Poliomyelitis	97	124	98	36	37
Pneumonia	24	12	11	11	10
Erysipelas	2	0	2	0	0
Undulant Fever	19	18	24	4	4
Cerebrospinal Meningitis	7	8	5	8	12
Malaria, contracted inside U. S.	0	1	0	0	2*
Malaria, contracted outside U. S.	10	16	26	11	0
Impetigo	21	8	3	1	4
Tularemia	2	1	4	0	1
Infantile Diarrhea	1	0	0	0	0
Food Poisoning	5	3	0	0	1
Rubella	1	2	2	5	0
Septic Sore Throat	1	6	26	13	3
Encephalitis	4	18	8	3	1
Amoebic Dysentery	1	2	1	0	0
Tetanus	1	3	1	1	0
Rocky Mountain Spotted Fever	1	6	4	0	0
Vincents Angina	3	0	5	1	0
Mumps	18	19	24	22	18
Conjunctivitis	3	0	0	1	0
Infectious Jaundice	1	3	1	1	0

* Not stated as to whether the disease was acquired outside or inside the United States.

Monthly Report—November 1946

Diseases	Nov. 1946	Oct. 1946	Sept. 1946	Nov. 1945	Nov. 1944
Tuberculosis, Pulmonary	256	158	292	...	...
Tuberculosis, Other Forms	4	5	5	...	...
Chickenpox	423	141	35	159	278
Impetigo	22	21	8	13	2
Measles	44	26	16	18	19
Septic Sore Throat	7	1	2	13	...
Rubella	2	1	2	2	2
Scarlet Fever	280	200	87	260	266
Malaria	13*	10-0	17*	10*	...
Conjunctivitis	3	3	...	...	...
Typhoid Fever	6	21	9	7	6
Diphtheria	46	48	18	62	32
Influenza	23	18	10	410	19
Pneumonia	31	24	12	9	4
Mumps	43	18	...	47	56
Poliomyelitis	65	97	124	13	15
Cerebro-Spinal Meningitis	4	7	8	12	14
Pneumococcic Meningitis	1	...	...	...	...
Meningococcic Meningitis	2	...	...	...	...
Tularemia	2	2	1	2	1
Undulant Fever	27	19	18	4	7
Erysipelas	3	2	...	4	1
Dysentery, Amebic	2	1	2	...	...
Encephalitis, Infectious	7	4	18	2	1
Sep. Meningitis	1	...	...	...	...
Dysentery	1	...	...	...	...
Whooping Cough	109	61	88	105	44

* Not stated as to whether the disease was acquired outside or inside the United States.

INDIANA STATE BOARD OF HEALTH ANNOUNCES NEW SEROLOGIC REPORT CARD

A NEW serologic report card (see facsimile) soon will be in use by the laboratory of the Indiana State Board of Health. It will be noted that the Mazzini standard flocculation and the Kolmer modification of the Wasserman complement fixation tests will be reported on blood specimens. The standard Mazzini test will be used as a screen on all specimens, and if negative no other test will be performed. However, in case a blood gives any degree of reaction with the Mazzini antigen, it will be tested with the Kolmer modification of the Wassermann technique. The results of both examinations will be reported, but instead of being expressed in numerical values as "1+, 2+, 3+ or 4+," as heretofore, the report will simply read "positive," "doubtful" or "negative."

Quantitative tests will not be made routinely, but only on cases indicated on the specimen cards as "massive arseno drip," "penicillin," or those under special study projects, or those which present diagnostic problems. The Mazzini quantitative test, and not the Kahn, will be performed on these and the result will be reported in terms of the number of "units" obtained. This numerical value will represent the highest dilution of the serum in which a complete reaction is observed and will be roughly one-fourth the number in terms of Kahn units.

The Kolmer-Wassermann test will be used on spinal fluids. The results of tests will not be reported in terms of "1+, 2+, 3+ or 4+," as formerly, but as "positive," "doubtful" or "negative" also. Values for the colloidal gold curve will be reported as heretofore.

The interpretation of these laboratory reports must be made by the attending physician and correlated with the history and clinical findings of the patient.

INDIANA STATE BOARD OF HEALTH

Indianapolis 7, Indiana

Specimen Received _____ Reported _____

Patient's Name _____

RESULTS OF SEROLOGIC TEST

Blood: Mazzini_____ Kolmer_____

Spinal Fluid: Kolmer 0.25 cc_____ 0.5 cc_____

Colloidal Gold_____

Remarks _____

SEROLOGIC REPORT

S.B.H. 3-1-4 ('46-50M)

SAMUEL R. DAMON, Ph. D.,
Director, Bureau of Laboratories

INTERPRETATION OF RESULTS

1. A positive or a negative report from the laboratory should not be construed as a diagnosis. The Physician makes the diagnosis—not the laboratory.
2. Positive tests unconfirmed by history or physical evidence of syphilis should be repeated to rule out technical errors and biologic false positives.
3. Doubtful tests should be repeated four times at intervals of three to seven days and a final evaluation of the results made.
4. A Negative reaction does not necessarily mean that the patient is free from syphilis.

INTERPRETATION OF SYMBOLS

1. AC means an anticomplementary reaction. Serologically it means neither positive nor negative.
2. QNS means quantity not sufficient for test.
3. A hemolyzed specimen is one unfit for testing. Frequent causes of hemolysis: Freezing in transit, bacterial growth, use of too hot syringe, forcing of blood from syringe.

Medical Panorama by the Associate Editor

PENNSYLVANIA has employed Raymond Rich and Associates to survey their public relations needs and to pass on applicants for acceptance as public relations counsel to the state society.

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PHILADELPHIA MEDICINE makes a strong plea for "more leisure for the general practitioner." The fact is indicated that, through general agreement, store-keepers, small businesses, office personnel, shop workers and "almost everyone in the spirit of the times insists upon and gets time which he can call his own, where he can play, read, visit with his family, or do whatever else he pleases to take him out of the grind of bread winning." That the general practitioner does not share in such an interval of leisure is partly due to the old established methods of practice and a lack of education of the public to its necessity. There seems to be no adequate reason why this could not be changed. Longer life, more pleasure, and interest in work and living are sufficient incentives for attaining this goal. Robert Louis Stevenson wrote: "It is by no means certain that a man's business is the most important thing he has to do."

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NEW JERSEY suggests a plan for absorption of "hospital orphans," those men in the "younger physician-veterans" group who are unable to secure hospital staff appointments. The suggestion is made that all hospitals co-operate by adding two or three of these men to their staffs. While this may solve the problem in communities where there are numerous hospitals, it does not provide the relief necessary in localities where there is only one hospital. There can be but one answer there—the admission of all qualified practitioners to staff membership.

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DETROIT MEDICAL NEWS, through its Editor, deplores the price relief has created in making permanent recipients of welfare benefits of those who, previously, had shown some effort to work out their benefits. He closes by saying, "What happened to the philosophy of the bespectacled prophets of the more abundant life, of which this is an end picture? It has made permanent pensioners of a segment of the populace. It has shown people that they can get something for nothing. It has jammed college courses in sociology—for as long as there is a gravy train both recipient and administrator will ride it."

MANY STATES are becoming perturbed over the operation of their veteran's care plans. In addition to many V.A. Clinics being set up in the larger communities, referrals generally are being made to specialists only, and red-tape and molasses still prevail. The promised plan for free choice of physician by the veteran has not yet materialized in fact.

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THE BULLETIN OF THE ALAMEDA County Medical Association gets so many quotes throughout the nation, because of the excellence of its material, we should like to join the parade:

"An intelligent program for a county medical society must include the following:

"1. Alone, together with other county societies, or through the state association, to provide voluntary sickness insurance for all who wish to avail themselves of it.

"2. To so organize the local profession and the mechanics of the distribution of medical care that there will be no sickness or suffering that goes unattended because the patient cannot qualify for public charity and lacks the financial resources to pay the full costs of private medical care.

"3. To provide a method of public protection and redress from excessive fees, unethical practice, negligence, and incompetence.

"4. To remove or control the third party in the economic relations of physicians and patients, such as heartless commercial collectors, bonus-minded secretaries of doctors, uninstructed business managers, et cetera.

"5. To study and act upon practices that are not in the public interest, to discipline unethical members aggressively and fearlessly, and to place the public interest ahead of the disagreeable task of self-discipline.

"6. To accept responsibility before the public for advice and guidance in everything relating to the health of the community and its citizens.

"7. To tell the public what has been done.

"If these objectives are accomplished by American medicine, there can be little doubt that the clamor for state medicine will cease. But none of these objectives, except the first, can be accomplished by the state or national organizations.

"They are the work of the county medical association.

"They are the objectives of the Alameda County Medical Association."

What's Going On In Indiana by the Executive Secretary

Fine Auxiliary Activity. The Woman's Auxiliary to the Floyd County Medical Society is sponsoring lectures on the effects of venereal disease before members of the New Albany High School. The auxiliary obtained consent of school authorities for these lectures. A male physician will speak to the boys, and a registered nurse will address the girls. This is certainly a commendable activity upon the part of the auxiliary. By such leadership in health education will medicine continue to hold its high place in the public's esteem.

——ISMA——

New Health Association. A new organization, to be known as the Indiana Public Health Association, has been formed to promote public health in Indiana. Temporary officers include Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association, as president, and Dr. Walter L. Portteus, as vice-president. A Constitution and By-Laws have been adopted. All persons engaged in the practice of public health, either directly or indirectly, and all persons interested in the advancement of public health, may become members by paying one dollar annual dues. It is provided in the Constitution that the Indiana association may become affiliated with the American Public Health Association. A one-day health conference is planned for spring or summer. Similar public health associations in other states have large memberships of physicians, and it is recommended that Hoosier doctors take an interest in this organization. Membership may be obtained by sending the annual dues to the temporary secretary, Miss Lucretia A. Saunders, health educator, State Board of Health, 1098 W. Michigan Street, Indianapolis 7.

——ISMA——

The State Legislature. The Legislative Committee received wholehearted support of the association membership during the 85th General Assembly which ended March 10. Legislation for better health laws was supported by the committee, and, of course, efforts of the cults to lower medical practice standards were opposed—successfully. With a few exceptions, members of the legislature were friendly to the medical profession. We did miss, however, having a physician in either the House or the Senate. It is hoped by the Legislative Committee that in 1949 the profession will have representation in one of the two bodies. The committee was gratified over the interest shown by doctors in legislation, and the fine response to requests that they contact their local senators and representatives. It is the doctor "back home" who has the most influence with a legislator.

——ISMA——

Material To Debaters. As the subject of adequate medical care is now being debated by Indiana high schools, the Bureau of Publicity sent a booklet entitled "Check and Double Check on Sickness Insurance" to more than a hundred high schools for use of the debating team members. In addition, the Bureau sent a list of the high school debate coaches to the Council on Medical Service of the American Medical Association for it to forward its literature against government-controlled medicine to them. The response to this activity upon the part of the Bureau was very gratifying. The debate coaches appreciated the information, and it has equipped the side opposing compulsory health insurance with the best arguments available.

——ISMA——

Caring for the Veterans. More than 1,300 Indiana physicians have signed with the Veterans Administration for care of ex-servicemen of World War II. That number is well beyond a third of the practicing physicians of our state, and it removes all doubt of medicine's desire and ability to take care of the 425,000 Hoosier veterans. Figures for November, December and January show that 4,451 veterans were examined in the field for compensation; 9,430 were given out-patient treatment (that is, from a doctor in private practice); and 1,386 were examined to determine the need for out-patient medical service. The program is working well, but some doctors are not recording all of their findings when making examinations for compensation. This is information that the rating board must have.

Deaths

Frank E. Bass, M.D., of Shelbyville, died on January fourth, at his home, following a brief illness. He was sixty-five years of age. Doctor Bass was a graduate of the Medical College of Indiana, in Indianapolis, in 1903, and had practiced in Shelbyville for the past thirty-one years. He was a member of the Shelby County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Peter C. Berns, M.D., of Linton, died on January sixteenth, at the home of a daughter in Detroit, Michigan, at the age of seventy-four years. He was a graduate of the Missouri Medical College, in St. Louis, in 1897, and had practiced medicine in the Linton community for almost forty years. Doctor Berns was a member of the Greene County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Samuel W. Hervey, M.D., of Fortville, died on January eighth, in Indianapolis. He was eighty-one years of age. Doctor Hervey graduated from the Medical College of Ohio, in Cincinnati, in 1891. He was a veteran of World War I, having served as Captain in the Army. Doctor Hervey was a member of the Hancock County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Guy M. Owsley, M.D., of Thorntown, died at his home on January eighteenth, after an illness of two months. He was sixty-four years of age. Doctor Owsley graduated from the University of Louisville School of Medicine, in Louisville, in 1905, and since that time has been practicing in the community of Thorntown. He had served as Coroner of Boone County. Doctor Owsley was a member of the Boone County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

Philip H. Schoen, M.D., of New Albany, died at his home on January twentieth, at the age of seventy-six years. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1898. Doctor Schoen had served as secretary of the Floyd County Medical Society, of which he was a member, for twenty-five years. He was also a member of the Indiana State Medical Association and a Fellow of the American Medical Association.

S. Kenosha Sessions, M.D., of Anna, Illinois, died at her home on January twenty-eighth, at the age of eighty-five years. Doctor Sessions graduated from the Northwestern University Woman's Medical School, in Chicago, in 1893. She had served as superintendent of the Indiana Girls School, at Clermont, for thirty years, and was an honorary member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Charles M. White, M.D., of Clinton, died at the Vermillion County Hospital, on January second, following a brief illness. He was ninety-three years of age. Doctor White graduated from the Jefferson Medical College of Philadelphia, in Philadelphia, in 1876 and had been practicing in Clinton for the past seventy years. He was a member of the Parke-Vermillion County Medical Society, the Indiana State Medical Association and the American Medical Association.

The following eulogy to Doctor White was written and presented to the Parke-Vermillion Medical Society, on January 15, by Paul B. Casebeer, M.D., of Clinton:

Dr. C. M. White was born September 20, 1853, on a farm three miles north of Clinton, Indiana. He was the tenth child born to Martha Elder White and James Anderson White.

At an early age Doctor White decided to become a physician. He was intrigued by the family physician, Dr. I. B. Hedges, and would sit and avidly watch the doctor prepare his medicines. He constantly talked of being a practicing physician, and at the age of eighteen he began to care for Doctor Hedges' office and read his books. In the fall of 1873 he enrolled at Michigan University for one year. Then he attended Jefferson Medical College and graduated with the Centennial Class of 1876.

After graduation he established an office in the back room of McBeth's Harness Shop, now Lewis Hardware Store. An epidemic of malaria and typhoid was raging soon after he opened his office, and Doctor White said "People could find no other physician, so they called me." There were many handicaps and difficulties to overcome in these pioneer days. Little was known about the cause of most diseases, therefore the remedy was unknown. Drugs were scarce and high priced—quinine sold for $8.00 an ounce. Mercury was used for syphilis, quinine for malaria, opium for pain, and calomel was used freely. The practice of medicine was on an expectant basis. It consisted of treating the symptoms as they presented themselves, and of anticipating and preventing complications.

There were no telephones, and doctors were called by messengers coming directly to their homes. Many night calls were made because the farmers worked late. Transportation was very difficult, as all roads were dirt and frequently unpassable. Doctor White made calls on ice skates, on foot, on horseback, by boat, and in two-wheeled carts.

Doctor White continued to practice in Clinton, and

he also continued to advance with the modern concepts of medicine. He was alert at all times, kind to all in his daily life, and was known to all as a fine gentleman. His will-power and determination drove him forward, and this is well demonstrated by the fact that he saw patients five days before his death, on January 2, 1947. Thus he completed over seventy years of faithful service in the practice of medicine in this community.

The writer of the personal history of men engaged in the various affairs of every-day life occasionally finds a subject whose record commands exceptional interest and the highest admiration. This is especially true when he has achieved more than ordinary success and has been a benefactor of his kind. Dr. C. M. White was eminently of that class. He has earned the indisputable right to rank in the van of the army of progressive men. His was a strenuous career devoted to the good of his fellows, and to the alleviation of their suffering. Many qualities were found in Dr. C. M. White's make-up that always gain success—a man of broad mind, strong will, keen discernment, sound judgment, and backed by an honesty of purpose—firm in his devotion to his profession. Truly, it can be said that Dr. C. M. White was a good doctor.

DEATHS OF INDIANA PHYSICIANS IN 1946

(Compiled by James B. Maple, M.D., Chairman of Committee on Necrology and History)

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death on Death Certificate
Bostwick, James G. (M)	67	Jan. 7	Mishawaka	Cerebral hemorrhage.
Morgan, Herman G. (M)	60	Jan. 8	Indianapolis	Malnutrition. Obstruction of transverse colon and small intestine.
Runyan, Herman C. (M)	68	Jan. 8	Alexandria	Acute circulatory collapse.
Baker, Jacob V. (M)	78	Jan. 11	Edinburg	Auto wreck.
Carter, Larue D. (M)	65	Jan. 22	Indianapolis	Coronary occlusion.
Crowder, Joseph R. (M)	71	Jan. 22	Sullivan	Myocarditis.
Rogers, Henry C. (R)	101	Jan. 30	Rockville	Cerebral hemorrhage. Arteriosclerosis.
Vance, Walter H. (M)	46	Feb. 9	Ft. Wayne	Coronary occlusion. Cardiac insufficiency.
Stroup, Charles C.	73	Feb. 14	Bloomington	Arterial hypertension.
Prather, Samuel A. (M)	72	Feb. 18	Vincennes	Cerebral hemorrhage. Diabetes mellitus.
Compton, Silas M. (M)	68	Mar. 5	South Bend	Lobar pneumonia. Pernicious anemia.
Collings, Thomas J. (M)	65	Mar. 6	Rockville	Coronary thrombosis.
Shimer, William (M)	67	Mar. 13	Indianapolis	Carcinoma of the bladder.
Luckett, Ernest R.	77	Mar. 28	Marengo	Heart disease.
Brown, Archibald (R)	69	Apr. 3	Rochester	Hypostatic pneumonia. Cerebral hemorrhage.
Silverburg, Shelton G. (M)	55	Apr. 4	Evansville	Cardiac asthma. Myocarditis. Enlarged heart. C.V.R.D.
Eicher, Floyd I. (M)	61	Apr. 5	Wakarusa	Cerebral hemorrhage.
Tracy, Bird Allen	80	Apr. 6	Hudson	Cerebral hemorrhage.
McArdle, Charles C. (M)	55	Apr. 17	Monroeville	Cirrhosis of the liver.
Lapenta, Vincent A. (M)	62	Apr. 20	Indianapolis	Cerebral hemorrhage. Hypertensive heart disease.
Bitting, Arvill W. (R)	75	Apr. 21	Bourbon	Cerebral hemorrhage.
Druley, Garner N. (M)	58	Apr. 25	Kokomo	Coronary thrombosis.
Ryan, Leo K. (M)	53	Apr. 25	Gary	Coronary thrombosis. Cerebral embolism.
Conner, David N. (M)	69	May 1	Markleville	Chronic nephritis.
Scherer, Simon P. (M)	80	May 3	Martinsville	Coronary sclerosis.
Kerrigan, John J. (R)	90	May 5	Michigan City	Chronic myocarditis. Bronchiectasis.
Bachrach, Moritz (M)	58	May 7	South Bend	Angina pectoris. Coronary thrombosis. Diabetes mellitus.
Grandstaff, Floyd L. (M)	40	May 11	Decatur	Lung abscess.
Beatty, James L. (R)	87	May 13	New Market	Cardiac insufficiency.
Smullen, Charles (H)	81	May 14	Rushville	Bulbar paralysis. Amyotropic lateral sclerosis.
Toles, Clarence A.	65	May 16	Indianapolis	Cardiovascular disease.
Martin, George E.	70	May 16	Williamsburg	Coronary occlusion. Endocarditis.
Hylton, Allen J.	84	May 18	Mooresville	Chronic myocarditis.
Hedrick, Robert M. (M)	56	May 20	Gary	Cerebral hemorrhage.
McLeay, John D. (M)	73	May 23	Indianapolis	Carcinoma.
Elliott, George W.	73	May 23	Wabash	Cerebral hemorrhage.
Little, Wendell D. (M)	54	May 23	Indianapolis	Coronary occlusion.
Verplank, Dean T. (M)	31	May 27	Gary	Suicide, gunshot.
Mowrer, Giles E.	72	May 28	Jeffersonville	Cardiovascular disease. Nephritis.
Stern, David H. (M)	38	June 13	Hammond	Acute coronary thrombosis.

Name	Age	Date of Death	Address	Cause of Death on Death Certificate
Resoner, W. S.	82	June 17	Swayzee	Chronic myocarditis. Myocardial degeneration.
Sigmon, Edwin L. (H)	80	June 20	Floyds Knobs	Prostatic hypertrophy. Urinary retention.
Laval, William J. (H)	86	June 28	Evansville	Arteriosclerotic heart disease.
Crabtree, L. R. (M)	58	June 28	Columbus	Coronary thrombosis.
Porter, George S. (M)	76	June 29	Williamsport	Hypostatic pneumonia. Cerebral hemorrhage. Generalized arteriosclerosis.
Hypes, Francis E. (M)	60	July 13	Nappanee	Cerebral hemorrhage.
Shipley, John B.	84	July 14	Hudson	Heart disease.
Hatfield, Sidney J. (M)	66	July 17	Indianapolis	Auto accident.
Draper, Ridley H. (M)	64	July 19	Bremen	Heart disease.
Hunt, George B. (M)	64	July 23	Richmond	Carcinoma of the liver.
Pearson, Edson D.	75	July 23	Wabash	Coronary thrombosis. Arteriosclerosis.
Dees, Harry E. (R)	64	July 28	Bicknell	Coronary thrombosis. Coronary arteriosclerosis.
Terhune, Rufus W. (M)	68	July 28	Martinsville	Chronic myocarditis. Chronic arteriosclerosis.
Batman, Fred H. (M)	68	Aug. 4	Bloomington	Cerebral hemorrhage.
Wooden, Edward I. (H)	80	Aug. 6	Rushville	Uremia. C.V.R.D.
Buck, George M.	69	Aug. 8	Bremen	Coronary occlusion. Coronary sclerosis. Generalized arteriosclerosis.
Knott, Harry (M)	62	Aug. 9	Plymouth	Cerebral arteriosclerosis. Hypostatic pneumonia.
Blackstone, John K.	84	Aug. 12	Crown Point	Chronic myocarditis.
Coonfield, Wm. M.	78	Aug. 26	Morgantown	Coronary occlusion.
Newcomb, John R. (M)	66	Sept. 3	Indianapolis	Myocardial failure.
Hatch, Robert W.	40	Sept. 8	Indianapolis	Portal cirrhosis.
Hunt, Lee F. (M)	69	Sept. 9	Anderson	Massive retroperitoneal hemorrhage. Dissecting abdominal aneurysm.
Ragsdale, Claude E.	77	Sept. 15	Trafalgar	Coronary thrombosis. Chronic myocarditis.
Nichols, Frank M.	37	Sept. 19	La Grange	Myocarditis. Toxic and infectious dermatitis. Allergic asthma.
Clark, Jediah H. (R)	78	Sept. 22	Connersville	Auto accident.
Faulkner, Albert S.	76	Sept. 25	Waynetown	Cerebral hemorrhage. Hypertension and hypertensive heart disease. Generalized arteriosclerosis.
Price, Corwin R.	69	Oct. 3	Geneva	Cerebral hemorrhage.
Shirar, Lewis (R)	86	Oct. 7	Camden	Cardiac dilatation. Arteriosclerosis.
Van Reed, Earl (M)	67	Oct. 10	Lafayette	Pulmonary embolus. Auricular fibrillation.
Bell, Daniel W.	68	Oct. 12	Otwell	C.V.R.D.
Thomson, John W. (M)	60	Oct. 17	Garrett	Uremia. C.V.R.D.
Weber, Louis (R)	71	Oct. 25	West Baden	Cerebral hemorrhage.
Pryor, David G. (M)	43	Oct. 27	Jeffersonville	Coronary occlusion.
Gauss, J. H. P. (R)	74	Oct. 31	Indianapolis	Cerebral thrombosis.
Jerome, Joseph N. (H)	77	Nov. 2	Evansville	Adenocarcinoma of lung.
Bridge, Morton L.	76	Nov. 3	Marion	Cerebral hemorrhage. Arteriosclerosis.
Shoemaker, Daniel A. (R)	80	Nov. 8	Muncie	Heart failure. Coronary occlusion. Arteriosclerosis.
Bosselmann, Clarence C. (M)	36	Nov. 7	Plymouth	Suicide, gunshot.
Mobley, Lewis F. (M)	71	Nov. 8	Summitville	Cerebral hemorrhage. Uremia.
Lambright, Simeon (H)	83	Nov. 9	Danville, Ill.	Hypostatic pneumonia. Chronic vascular disease. Chronic arteriosclerosis.
Rinne, John L., Jr. (M)	34	Nov. 9	Indianapolis	Auto accident.
Valentine, E. J. (M)	45	Nov. 16	Shelbyville	C.V.R.D.
Hassenmiller, Martin (M)	77	Nov. 18	West Baden	Cerebral hemorrhage.
Dilley, Fred C. (M)	70	Nov. 21	Brazil	Coronary occlusion. Arteriosclerosis. Cervical arthritis.
Palmer, Earl (M)	64	Nov. 24	Logansport	Acute dilatation of the heart. Chronic nonvalvular heart disease.
Spigler, Otto R. (M)	71	Nov. 28	Terre Haute	Coronary occlusion. Arterial hypertension.
Belden, Louis D. (M)	57	Nov. 28	Indianapolis	Coronary thrombosis. Congestive heart failure.
Reeder, Joseph C.	91	Nov. 28	Montezuma	Uremia. Chronic myocarditis.
Smith, Mary E. Thomas	74	Dec. 3	Indianapolis	Chronic myocarditis. Arteriosclerosis. Hypertension. C.V.R.D.
Ristine, Warren H.	96	Dec. 5	Lakeland, Fla.	Senility.
Goldthwaite, Harmon R. (M)	63	Dec. 8	Marion	Coronary thrombosis. Obesity.
Martin, Francis V. (M)	80	Dec. 13	Michigan City	Coronary occlusion.
Lawson, Wilson T. (H)	97	Dec. 14	Danville	Uremia. Prostatism.
Freeman, George M.	77	Dec. 20	Shoals	C.V.R.D.
Kilgore, Frank T. (M)	70	Dec. 22	Yorktown	Arteriosclerotic cardiovascular disease. Coronary insufficiency.
McCarty, Perlee W.	76	Dec. 23	Indianapolis	Bronchopneumonia. Arteriosclerosis. C.V.R.D.
Sholty, Lloyd O. (M)	62	Dec. 24	Lafayette	Coronary thrombosis.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

January 12, 1947

The Council of the Indiana State Medical Association convened for its midwinter meeting at 9:20 A.M., Sunday, January 12, 1947, in the Chateau Room, Claypool Hotel, at Indianapolis, with Dr. A. M. Mitchell, of Terre Haute, presiding. Roll call showed the following present:

Members of the Council:

First District	I. C. Barclay, Evansville
Second District	Not represented
Third District	A. P. Hauss, New Albany
Fourth District	C. F. Overpeck, Greensburg
Fifth District	A. M. Mitchell, Terre Haute
Sixth District	W. U. Kennedy, New Castle
Seventh District	C. J. Clark, Indianapolis
Eighth District	E. H. Clauser, Muncie
Ninth District	Wemple Dodds, Crawfordsville
Tenth District	Not represented
Eleventh District	C. S. Black, Warren
Twelfth District	Paul A. Garber, South Whitley
Thirteenth District	Alfred Ellison, South Bend

Officers:

J. E. Ferrell, Fortville, president 1946.
Floyd T. Romberger, LaFayette, president 1947.
Cleon A. Nafe, Indianapolis, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
E. M. Shanklin, Hammond, editor of THE JOURNAL.
Albert Stump, Indianapolis, attorney.
Thomas A. Hendricks, Chicago, executive secretary emeritus.
Ray E. Smith, executive secretary.

Legislative Committee:

Norman M. Beatty, Indianapolis, co-chairmen.
J. William Wright, Indianapolis, co-chairmen.

Delegates to the A.M.A.:

Don F. Cameron, Fort Wayne.
F. S. Crockett, LaFayette.
H. G. Hamer, Indianapolis.

L. E. Burney, Indianapolis, State Health Commissioner.
W. L. Portteus, Franklin, president, Indiana Health Officers' Association.
J. T. Oliphant, Farmersburg, member, State Board of Health.
Charles F. Thompson, chairman, Veterans Committee.

On motion of Dr. Hauss, seconded by Dr. Garber, the minutes of the Council meetings held at Indianapolis on October 29 and 31, 1946, were approved as printed in the December, 1946, issue of THE JOURNAL.

Reports of Councilors

Brief, informal reports of the councilors indicated that all of the districts are well organized and are functioning. In addition, the following matters were discussed:

Dr. I. C. Barclay, 1st District—The executive secretary read a letter which Dr. Barclay had received from Dr. Minor Miller, Evansville, in which Dr. Miller registered objection to the establishment by the State Board of Health of "branch offices of the State Board of Health throughout the state." This subject was discussed by Drs. Barclay, Mitchell and Ellison and deferred for further discussion following Dr. Burney's talk on the legislative program of the State Board of Health.

Dr. A. P. Hauss, 3rd District—Dr. Hauss called attention to an editorial entitled, "An Indiana Doctor Dramatizes a Need," which appeared recently in *The Louisville Courier-Journal* as a result of the publicity given an Indiana doctor, who, having decided to leave a community of 2,500 persons to accept a position in an eastern hospital, drove out thirty miles and came back to resume a rural practice among people who needed him. The editorial read in part:

> "So much has been said already of the trend of medical graduates toward the cities and away from the unrewarding role of the country doctor that there is no need to underscore again the cause of it.
>
> "But there are few Dr. Blanks. The Kentucky State Medical Association's scholarship fund for rural physicians is a splendid effort to help bring the country doctor back. It deserves generous and general support. But it will operate slowly. And unless it accomplishes something like a miracle, the time may not be far off when it will become an obligation of the state to see that the greatest part of its people are delivered from the hazard of inadequate medical care."

Dr. Hauss said, "I think the establishment of scholarships for doctors in rural areas is something that the Indiana State Medical Association should consider; I think it is something that the pharmaceutical houses should consider."

Dr. W. H. Howard, 10th District, mailed in the following report, which was read by the secretary:

> "The Tenth District Medical Society met at Phil Smidt's restaurant in North Hammond on the evening of October 10. Dr. A. C. Remich of Hammond, secretary, presided in the absence of Dr. George M. Cook, Hammond, president.
>
> "The program dealt with the home-town care of veterans. The speakers were Dr. B. A. Cockrell, chief medical officer, Veterans Administration, Chicago Area, and his chief assistant, Dr. C. H. Ogden. Seventy were in attendance.
>
> "In our Lake County Medical Society, the inauguration of health education bulletin known as the 'Ounce of Prevention' was started in October. This bulletin is now going to 4,000 school teachers, public health workers, social workers, plant personnel departments, etc., throughout our community. The 'Ounce of Prevention' was conceived by the Lake County Medical Society and produced under its direction, the cost of the bulletin being

borne by the Tuberculosis Association, Cancer Society and the Infantile Paralysis Foundation. This co-operative project has brought many compliments including the American Medical Association, Harvard University, the University of Michigan, and many others. The Council on Medical Service of the A.M.A. sent 3,500 of the November issue throughout the United States as a sample of good community relations and a contribution to health education.

"The mass x-ray program for the early diagnosis of tuberculosis is now under way, the equipment having arrived in early December. The T. B. Association is carrying out the program as set up by our Society.

"The Society has held regular monthly meetings this fall, and at present is considering the raising of fees for welfare and township medical service. There is also consideration being given to the establishment of a cancer clinic, which would help in the early diagnosis of cancer, or some other program in conjunction with the Cancer Society. It is our feeling that the Medical Society should cooperate and give guidance to the Cancer Society in its efforts for cancer control.

"I am very sorry not to be able to submit this report in person but it was absolutely necessary that I be out of the city on business over which I have no control."

Dr. Paul A. Garber, 12th District, reported that the Twelfth District Society meeting would be held at Fort Wayne on May 6, 1947.

The chairman called attention to the dates set for the annual session of the American Medical Association to be held at Atlantic City, June 9 to 13, 1947, and to the fact that district meetings should not conflict with each other or with the A.M.A. meeting.

Reports of Officers

Dr. Floyd T. Romberger, president—"It is a very great pleasure indeed to report to you that I believe, insofar as I know, the affairs of this association are running along very, very smoothly. The headquarters office is operating at super-duper efficiency. Our JOURNAL speaks for itself. Our financial condition is sound, and I congratulate this Council on the very great expertness with which it has managed the affairs of this association. In regard to committee appointments for this year, it seemed advisable to reduce the number of committees and it also seemed advisable, from many angles, to reduce the number of members on these committees in order to attain real progress in the efficiency of this organization. I believe we have a great year ahead of us. The Executive Committee and the Committee on Public Policy and Legislation have been working admirably smoothly. If there is anything I can do, I am certainly at your call."

Dr. Cleon A. Nafe, president-elect and chairman of Executive Committee—"I have already stated to you that I appreciated the honor of being selected as your president-elect. Now, my term as chairman of the Executive Committee is at an end and I want to say to this Council that during the ten years that I have served I have appreciated the opportunity and privilege of sitting with you and serving with the other members of that committee. It has been a lot of work but also a lot of fun. I want to reiterate what Dr. Romberger has said—everything seems to be in fine order. Our executive office is functioning fine, but, as you all know, we have a lot of problems. I have appreciated the pleasure of serving as chairman of the Executive Committee, and I want to express to this Council that appreciation."

Dr. A. F. Weyerbacher, treasurer, presented the following report which was compiled by George S. Olive and Company, certified public accountants:

Treasurer's Report

January 8, 1947

The Council,
Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1946. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1946; and, (3) statements of receipts and disbursements of all funds, year ended December 31, 1946. A list of the statements is presented on the first page following this text.

General Comment

In exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1946, showing in summary form the sources from which this increase was derived.

The increase of $4,744.46 results principally from an excess of operating cash receipts over operating cash disbursements of the general fund. Increases in the general fund are due mainly to additional income from membership dues and from exhibit rents, offset by increases in headquarters office expense and annual session expense. A complete analysis of these increases and decreases is presented in exhibit C.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1946, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the general fund, of THE JOURNAL of The Indiana

State Medical Association, and of the Medical Defense fund are presented in exhibits C, D, and E.

Yours very truly,

GEO. S. OLIVE & CO.
Certified Public Accountants.

INDIANA STATE MEDICAL ASSOCIATION
List of Statements Contained in Report on Examination of Cash Records, Year Ended December 31, 1946

Exhibit A—Analysis of increase in assets, all funds, year ended December 31, 1946

Exhibit B—Statement of assets, all funds, at December 31, 1946

Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1946, and December 31, 1945

Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1946

Exhibit E—Statement of cash receipts and disbursements of the Medical Defense fund, year ended December 31, 1946

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds
Year Ended December 31, 1946

TOTAL ASSETS, DECEMBER 31, 1946—Exhibit B		$56,542.39
TOTAL ASSETS, DECEMBER 31, 1945		51,797.93
NET INCREASE		$ 4,744.46
Arising from the following sources:		
Excess of operating cash receipts over operating cash disbursements, general fund, year ended December 31, 1946:		
Receipts—Exhibit C	$46,630.70	
Disbursements—Exhibit C	42,046.37	
		$4,584.33
Excess of operating cash receipts over operating cash disbursements, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1946:		
Receipts—Exhibit D	37,941.01	
Disbursements—Exhibit D	37,558.88	
		382.13
Excess of operating cash disbursements over operating cash receipts, Medical Defense Fund, year ended December 31, 1946:		
Receipts—Exhibit E	2,865.50	
Disbursements—Exhibit D	37,558.88	
		(222.00)
TOTAL NET INCREASE		$4,744.46

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Statement of Assets, All Funds, at December 31, 1946

GENERAL FUND:			
Cash on deposit—Exhibit C			$ 5,613.25
Petty cash fund			200.00
Investments:			
Marion County Flood Prevention bonds	$ 3,000.00		
Indianapolis City Hospital bonds	5,000.00		
U. S. Treasury bonds	13,000.00		
U. S. Savings bonds	5,000.00		
		26,000.00	
Total general fund			$31,813.25
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			6,445.42
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		3,283.72	
Investments:			
Marion County Flood Prevention bonds	2,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	5,000.00		
U. S. Baby bonds	3,000.00		
		15,000.00	
Total Medical Defense fund			18,283.72
TOTAL ASSETS, ALL FUNDS—Exhibit A			$56,542.39

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION
Comparative Statement of Cash Receipts and Disbursements,
Years Ended December 31, 1946, and December 31, 1945

	Year Ended Dec. 31, 1946	Dec. 31, 1945	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$1,028.92	$465.91	$563.01
RECEIPTS:			
Membership dues	35,776.00	33,603.00	2,173.00
Income from exhibits	9,926.00	5,695.00	4,231.00

Interest income:			
U. S. Treasury bonds	290.65	368.75	(78.10)
U. S. Savings bonds	125.00	125.00	
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	
Marion County, Indiana, Flood Prevention bonds	127.50	127.50	
Refund on convention expense		69.56	(69.56)
Petty cash refund—contra		500.00	(500.00)
Reimbursements from American Medical Ass'n.	72.41	194.15	(121.74)
Check for Dunninger fee		1,250.00	(1,250.00)
Travel refunds	113.14		(113.14)
Miscellaneous income		56.02	(56.02)
	46,630.70	42,188.98	4,441.72
BEGINNING BALANCE PLUS CASH RECEIPTS	47,659.62	42,654.89	5,004.73
DISBURSEMENTS:			
Transfer of applicable portion of dues to THE JOURNAL of The Indiana State Medical Association—Exhibit D	6,980.00	6,726.00	254.00
Medical Defense fund—Exhibit E	2,515.50	2,439.00	76.50
Headquarters office expense	13,499.43	11,384.80	2,114.63
Publicity committee	1,834.98	2,476.37	(641.39)
Public policy	325.99	1,403.74	(1,077.75)
Council	6,702.41	6,267.24	435.17
Officers	474.05	496.75	(22.70)
Annual session	6,700.03	4,750.98	1,949.05
Miscellaneous committees	1,756.31	2,353.95	(597.64)
Federal old age benefit tax	85.65	93.39	(7.74)
Instructional course expense	15.63		15.63
Refunds of dues	372.00	36.75	335.25
Petty cash refund—contra		500.00	(500.00)
National Conference on Medical Service	585.98	147.59	438.39
Miscellaneous expense		15.26	(15.26)
Payments for American Medical Ass'n	72.41	194.15	(121.74)
Funds transferred to Medical Defense fund		2,000.00	(2,000.00)
Refunds on exhibit rent	126.00	340.00	(214.00)
	42,046.37	41,625.97	420.40
CASH BALANCE AT END OF YEAR	$5,613.25	$1,028.92	$4,584.33

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1946

The Journal of The Indiana State Medical Association

BALANCE, JANUARY 1, 1946		$6,063.29
RECEIPTS:		
Subscriptions—members—Exhibit C	$6,980.00	
Subscriptions—non-members	394.42	
Advertising	30,410.93	
Collection on accounts receivable	66.05	
Single copy sales	40.50	
Electrotypes	49.11	
Total receipts—Exhibit A		37,941.01
		44,004.30
DISBURSEMENTS:		
Salaries	12,156.73	
Printing	21,283.49	
Office postage	352.01	
Journal postage	603.35	
Advertising commissions	422.40	
Electrotypes	699.19	
Reporting	125.50	
Press clippings	65.85	
Editor and editorial board expense	91.76	
Office supplies	773.82	
Rent	440.00	
Electricity	41.59	
Telephone and telegraph	239.17	
Federal old age benefit tax	87.71	
Miscellaneous	176.31	
Total disbursements—Exhibit A		37,558.88
BALANCE, DECEMBER 31, 1946—Exhibit H		$6,445.42

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1946

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1946		$3,505.72
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—Exhibit C	$2,515.50	
Interest income:		
U. S. Treasury bonds	140.00	
U. S. Savings bonds	125.00	
Marion County Flood Prevention bonds	85.00	
Total receipts—Exhibit A		2,865.50
		6,371.22
DISBURSEMENTS:		
Malpractice fees	1,250.00	
Attorney fees	1,800.00	
Treasurer's bond	37.50	
Total disbursements—Exhibit A		3,087.50
BALANCE, DECEMBER 31, 1946—Exhibit H		$3,283.72



indications for "smoothage"

"smoothage"—the gentle, non-irritating action of Metamucil—is indicated in any type of constipation or other gastrointestinal dysfunction requiring a mild, soothing but effective stimulant to bowel evacuation.

metamucil provides a soft, bland, plastic bulk which exerts a stimulating effect on the bowel reflexes and facilitates elimination of the fecal content in a completely normal and natural manner.

metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

Dr. E. M. Shanklin, editor of THE JOURNAL—"Pauleys will continue to print THE JOURNAL in 1947 under our 1946 contract, with an increase of 15 per cent in printing costs. We think we have a better JOURNAL than ever before. With some changes made in THE JOURNAL staff I believe you will find that there will be a continued improvement in the scientific, editorial and mechanical appearance of your JOURNAL during the ensuing year. The 1947 Year Book is one of the largest journals we have ever published.

"I sent to the Council last November an outline giving my ideas of what the Editorial Board should be and should do. If the Council has any directions as to the Editorial Board from now on, we would be pleased to hear from you."

Unfinished Business

1. *Report of the Committee for the Study of Nursing Service.* Dr. Clark, chairman, reported that at a conference in December with the president and executive secretary of the Indiana State Nurses Association, he learned that the national nursing association, at its September meeting at Atlantic City, had provided that a program for getting more nurses' aides be instituted in the various states. "The Indiana State Nurses Association already had gone ahead with the plan. In co-operation with the State Department of Education they are rapidly arriving at a plan to supply the necessary equipment, the necessary instruction, and to arrange the entire program for a plan to train not 'nurses aides' but 'technical assistants.' Such a plan is now in the process of being prepared and is to be presented to the Indiana State Nurses Association for its approval. The president and the executive secretary of the Indiana State Nurses Association are more concerned with their ability to sell their group than with any other thing.

"The general plan includes two groups: (1) High school students who would major in nursing training, and (2) A night school group for older women who are doing other work during the day. These women can go into this night school group and qualify themselves to be technical assistants.

"As you know, the state law provides that any hospital having a graduate nursing training school cannot operate a practical nurses' training school. They cannot train nurses to go out in the homes but they can train people to work in their own hospitals.

"The state nursing group feels that subsidization was the downfall of the Red Cross nursing aide program. Immediately upon stopping the financial return to these girls, all of them left their work in hospitals. They have the feeling that if the individual isn't sincere and honest, everyone would be wasting his time and effort trying to train that person.

"I extended to the Indiana State Nurses Association our earnest effort in our desire to co-operate with them. They already have established their own liaison with our association; we can't dictate to them about that. I feel, however, that members of liaison committees to special groups should be asked to make reports to the Council, the House of Delegates, or the Executive Committee.

"That is the situation as it stands. They are progressing quite rapidly, I think, with the final objective of giving adequate nursing care."

This problem was discussed further by Drs. Ellison, Crockett, Portteus, Hauss and Mr. Stump.

2. *Progress of Mutual Medical Insurance, Inc.* Dr. Kennedy reported that as of January 1, 1947, the net assets of this company were $183,000, surplus $49,000, and total membership 91,000.

3. *Medical Care of Veterans.* Dr. C. F. Thompson, chairman of the Veterans Committee, reported as follows: "During the year 1946 your Veterans Care Committee met three times with the director of outpatient service of the Veterans Administration and his staff. Other than advisory suggestions and clarification of questions and criticisms with regard to medical care to veterans under the existing agreement with the state association, there were answers to two questions rendered:

(1) With regard to the extensive use of heat and light therapy in chronic diseases it was suggested that two weeks' trial of such therapy in any injury or disease which had existed for more than one year was sufficient to determine the benefit of such treatment, or the possibility of benefit from additional similar treatment.

(2) Misinterpretation of the fee schedule, resulting in duplication of fees for services rendered, was clarified in the articles devoted to the subject of medical care to veterans in the state medical JOURNAL.

"Up to January 1, 1947, 1,600 doctors in the state have been accepted by the Veterans Administration as fee-designated physicians under the agreement with the state association. Of this total number accepted, the services of 1,100 have been used to date. There have been no instances of gross neglect in medical care or ethical error by doctors rendering service under the agreement for medical care to veterans in Indiana."

4. *Letter from Ora L. Wildermuth.* The chairman read a letter received from Ora L. Wildermuth, president of the Board of Trustees of Indiana University, acknowledging receipt of a copy of the resolutions "favoring the moving of the first year of medicine to the Medical Center at Indianapolis as soon as possible" and suggesting that the "Medical Center be placed under its own supervision and own budget that it may then be able to secure the best of medical talent for teaching," which were adopted by the House of Delegates at its meeting on October 31, 1946. Mr. Wildermuth's letter read in part as follows:

> "I am not quite sure what the second part of this resolution means. If you mean by 'own supervision'

CLAIMS

VS.

DIFFERENCES

WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are *made* differently. In the clinic as well as in the laboratory, the *advantages* of PHILIP MORRIS have been repeatedly observed, repeatedly reported by *recognized authorities* in leading medical journals. Yes, PHILIP MORRIS *claims* superiority . . . *and that superiority has been proved.**

May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS—*the one cigarette proved definitely less irritating.*



PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.,
119 FIFTH AVENUE, N. Y.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

that the Medical School is to become a separate institution, wholly independent of the University, then I think I should seriously object. It once was under its own supervision as were a very large number of medical schools throughout the country, but the trend has all been toward putting these schools under university jurisdiction, and if you have in mind going back to separate control, then you are definitely recommending a step backward which I would not favor. I could give you many reasons for my opinion.

"Please understand that these expressions are purely my own and do not in any sense represent Board sentiment."

Dr. Clark: I don't think we ever had any idea of having a separate institution. Our recommendation is that the first year be moved to Indianapolis. I think the secretary should be instructed to convey that information to Mr. Wildermuth. I make that as a motion. (Motion seconded by Dr. Garber, and carried).

Dr. Clark announced that this year the course in medical economics which was formerly given at the medical school will be re-established. "There also will be a one-week postgraduate course of the same general character that has been held previously and also a course such as is conducted at LaFayette. We hope to enlarge the courses in the basic sciences and to make them available to those individuals in private practice who are attempting to qualify themselves for the Board. We intend to continue to supervise and aid in the training of the medical, surgical and special residents of the Veterans Administration. (Their training shall be conducted by and under the supervision of the medical school in the locality in which they exist). The course for general practitioners each month will be continued. We hope to encourage doctors who come to the city for a few hours to utilize the facilities of the University and city hospitals."

The chairman also read a letter from H. B Wells, president of Indiana University, saying that the resolutions regarding the medical school would be placed on the agenda of the next meeting of the Board of Trustees of the University.

Suggestions and Proposals for 1947 (98th) Annual Session at French Lick

1. *Dates set by Executive Committee*—Tuesday, Wednesday and Thursday, October 28, 29 and 30, 1947.

2. *Instructional courses.* Dr. Clark made a motion that instructional courses be held at French Lick. Motion seconded by Dr. Black, and passed. These courses are to be held on Tuesday.

3. *General and section meetings.* Following discussion by Drs. Mitchell and Hauss, Dr. Clark moved that the entire day of Wednesday be devoted to general scientific meetings, that sectional meetings be held on Thursday morning, and that the final Council and House of Delegates meetings be scheduled for 11:30 a.m. Thursday. These arrangements mean that this would be a full three-day session. Motion seconded and carried.

4. *Annual banquet.* It was suggested that the banquet might be held on Thursday evening instead of Wednesday evening. Decision on this point was deferred until the April meeting of the Council.

5. *Stag smoker.* Dr. Hauss stated that the entertainment committee might want this event to be a joint frolic for both men and women this year. Definite decision on this is to be made at the April meeting of the Council.

6. *Budget.* Dr. Clark made the motion that an appropriation of $3,000 be allowed the local Convention Arrangements Committee for convention expenses. Motion seconded by Dr. Garber, and passed.

7. *Scientific exhibit.* Dr. Clark moved that a scientific exhibit should be held this year. Motion seconded by Dr. Barclay, and passed.

8. *General outline of program,* including the foregoing suggestions, follows:

Monday, October 27, 1947

Meeting of health officers.
Executive Committee dinner and meeting.

Tuesday, October 28, 1947

Morning— Registration.
Instructional courses.
Commerical and scientific exhibits.
Annual golf tournament.
Skeet and trap shoot.
Editorial Board meeting.

Afternoon—Council meeting.
Meeting of House of Delegates.
Instructional courses.

Evening— Stag party or other entertainment.
Dinner for women physicians.

Wednesday, October 29, 1947

Morning— General scientific meeting.

Noon— Class and fraternity get-togethers and luncheons.
Veterans' luncheon.

Afternoon—General scientific meeting.

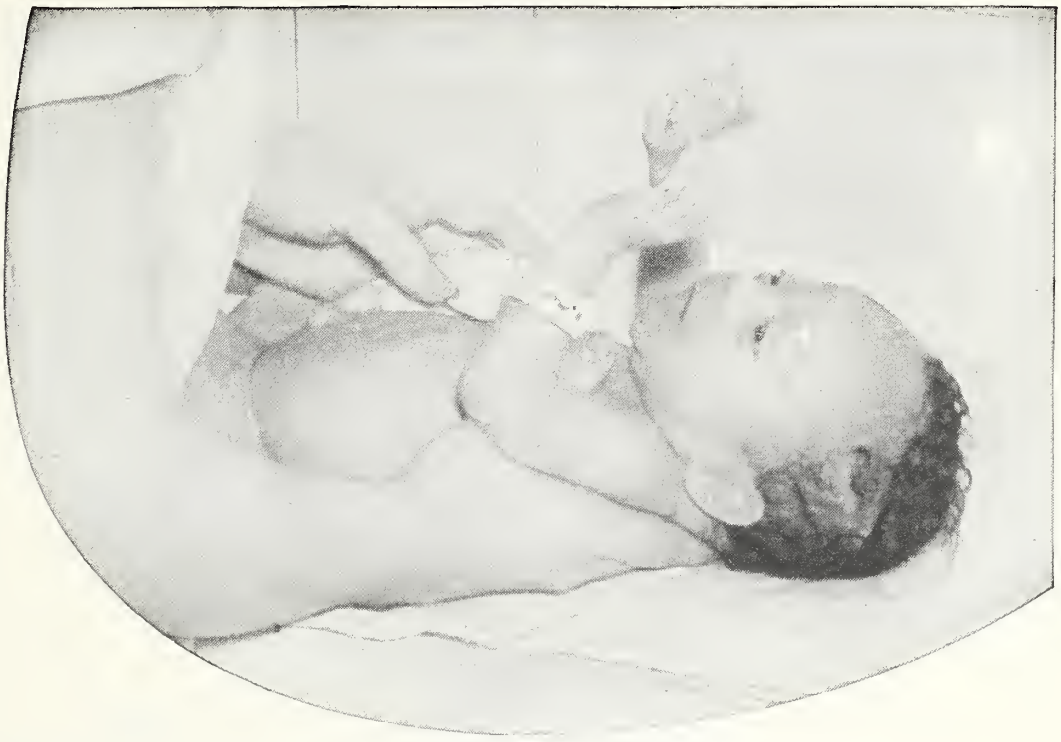
Evening— Annual dinner. (May be held Thursday).

Thursday, October 30, 1947

Morning— Section meetings.
Final House of Delegates' meeting.
Final Council meeting.

MEMBERSHIP PROBLEMS

1. *Membership report.*



Premature, but promising

To the premature struggling for existence, intestinal distention, colic or diarrhea may be insurmountable obstacles. Good care and good nutrition, however, offer promising prospects for life and health.

In the feeding of premature infants, 'Dexin' has proved an excellent "first carbohydrate." Because of its high dextrin content, it (1) resists fermentation by the usual intestinal organisms, (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds.

Readily soluble in hot or cold milk, or other bland fluids, 'Dexin' brand High Dextrin Carbohydrate is well taken and retained. 'Dexin' *does* make a difference.

'Dexin' HIGH DEXTRIN CARBOHYDRATE
BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
'Dexin' Reg. Trademark

Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.

MEMBERSHIP REPORT

Indiana State Medical Association
December 31, 1946

County Society	No. M.D.'s in* County	Members Dec. 31, 1946	Members Dec. 31, 1945	Loss— Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	15	13	12	1		1	3		
*Vanderburgh	198	161	162	—1	27	5	9	3	4
Warrick	19	13	13		1	2	7		
Spencer	13	7	10	—3	4		2		
Perry	12	11	11						1
*Gibson	28	26	26		2	1	2		
Pike	13	9	12	3	2		2	1	
Total	298	240	246	—6	36	9	25	4	5
2nd District									
*Knox	56	45	41	4	5	7	3	2	1
Daviess-Martin	27	22	23	—1	3	1	1	1	1
Sullivan	25	19	21	—2	3	1	5	1	
Greene	21	20	20		1	1			
Owen	9	8	10	—2	1		1		
*Monroe	37	34	35	—1	2	2	1	2	
Total	175	148	150	—2	15	12	11	6	2
3rd District									
Lawrence	29	23	20	3	2	2	5	1	
*Orange	14	11	13	—2	3		2	1	
Crawford	7	6	6				1	1	
*Washington	9	9	12	—3			1		
Scott	8	5	4	1			3		
Clark	29	24	21	3	3	2	1	2	1
*Floyd	41	38	39	—1	1	2	2	2	
Harrison	9	8	10	—2	1				
*Dubois	19	17	17		2		1		
Total	165	141	142	—1	12	6	16	7	1
4th District									
Brown									
*Bartholomew	40	33	28	5	2	5	3	1	3
Decatur	19	16	16		1	1	3		
*Jackson	19	18	18				1		
*Jennings	6	6	11	—5			1		
Ripley	13	12	13	—1	1	1			
Jefferson	28	21	19	2	5	4	3		
Switzerland	6	5	5		1	1			
*Dearborn-Ohio	20	18	18				1		2
Total	151	129	128	1	10	12	12	1	5
5th District									
Parke-Vermillion	35	24	26	—2	7	3	1	3	1
Putnam	22	19	19		1	2	2		2
*Vigo	118	104	101	3	7	3	7	1	5
*Clay	18	17	17		1		1	1	
Total	193	164	163	1	16	8	11	5	8
6th District									
*Hancock	25	23	26	—3	1		1		
*Henry	40	37	38	—1	2	1	1		1
Wayne-Union	76	65	62	3	4	6	6	2	3
Rush	16	16	14	2		1	1	2	
*Fayette-Franklin	24	18	18		3		1		2
Shelby	35	25	26	—1	6		5	1	
Total	216	184	184		16	8	15	5	6
7th District									
*Hendricks	23	21	17	4	1	3	2	1	1
Marion	961	818	730	88	88	104	47	14	23
*Morgan	29	20	20		4	1	3	3	1
Johnson	20	16	14	2	1	4	2	2	1
Total	1033	875	781	94	94	112	54	20	26
8th District									
Madison	96	81	82	—1	6	6	5	4	3
*Delaware-Blackford	114	87	88	—1	18	2	11	1	3
Jay	22	18	21	—3	3		2		
Randolph	28	26	23	3	1	3	1		
Total	260	212	214	—2	28	11	19	5	6
9th District									
Benton	9	8	9	—1	1				
*Fountain-Warren	22	21	20	1	1		3	2	
*Tippecanoe	104	95	96	—1	6	3	5	2	1
Montgomery	38	30	31	—1	3		6	1	
Clinton	29	25	23	2	2	1	2		
Tipton	18	13	12	1	2		3		
Boone	24	18	18		4		2		
Hamilton	27	22	21	1	2		4		1
White	7	3	3		1		2		1
Total	278	235	233	2	22	4	27	5	3
10th District									
Lake	303	263	248	15	25	25	17	5	3
Porter	28	25	26	—1	2		3		
*Jasper-Newton	23	19	16	3	2	2	4		
Total	354	307	290	17	29	27	24	5	3
11th District									
*Carroll	15	14	13	1			1	1	
Cass	53	38	40	—2	9	1	8	1	1
*Miami	23	18	22	—4	4				1
*Wabash	29	24	22	2	2	1	3	1	1
Huntington	26	25	26	—1		2	1		1
Howard	47	37	37		4	3	5	1	2
*Grant	65	57	48	9	2	8	7	3	1
Total	258	213	208	5	21	15	25	7	7
12th District									
LaGrange	5	5	5						
Steuben	17	10	11	—1	4		1	2	
*Noble	27	25	25		2	1	3		
DeKalb	26	22	22		2	1	4	1	
Whitley	17	11	12	—1		1	3		4
*Allen	208	184	176	8	11	9	10	3	10
*Wells	29	24	21	3	2	4	3		
*Adams	21	18	20	—2		1	1	2	2
Total	350	299	292	7	21	17	25	8	16
13th District									
*LaPorte	69	51	65	—14	16	2	3	2	
*St. Joseph	196	168	170	—2	11	7	16	3	5
Elkhart	91	76	72	4	6	5	10	2	1
Starke	4	3	4	—1	1				
Pulaski	8	6	7	—1	2				
Fulton	15	13	13		1	1	1		
Marshall	31	27	25	2	1	3		2	3
Kosciusko	23	14	10	4	6	1	2	1	
Total	437	358	366	—8	44	19	32	10	9

The advice is always "SEE YOUR DOCTOR"

For over 18 years, Parke, Davis & Company has conducted an educational advertising campaign in behalf of the medical profession — teaching the importance of prompt and proper medical care. Now appearing in color in LIFE and other leading magazines, these "See your doctor" messages reach an audience of *more than 23 million people.*

Some things you should know about heart disease

No. 202 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IT IS true that heart disease is the greatest single cause of death in this country.

But it is not true, as many people think, that heart disease must automatically cut short your life or make you an invalid.

A common type of heart disease—the so-called "functional" type—is not actually heart disease at all. It is the reflection of some other, usually correctable, disturbance in the body. It is often merely a temporary condition. It does not alter the heart itself, nor does it shorten life.

Even "organic" heart disease, which actually changes the heart's structure, need not be a serious disability. The handicap it imposes on a normal life will vary widely —with the nature of the disease and the individual case.

Symptoms are no indication of the seriousness of a heart condition.

Two men may have identical symptoms. One man's heart condition may dictate a careful limitation of his activities. The other man may be able to live a normal life span with only slight restrictions on his way of living.

Medical science during the past few years has made great progress in understanding the nature of heart disease, and in developing new methods of prevention and treatment.

Doctors today, by proper treatment of rheumatic fever in children, prevent many future cases of heart disease. And today doctors can also *cure* some cases of heart disease which would have been considered hopeless a few years ago.

There is, for instance, a kind of heart disease known as subacute bacterial endocarditis. A few years ago doctors were helpless in combatting what was practically always a fatal infection. But now, through the use of penicillin, an increasing number of cases are being successfully treated.

Other drugs help your doctor to regulate the action of an irregular heart and to reduce the strains that are put upon it.

And his modern knowledge of diet and vitamins, and the prevention of anemia and acute respiratory infections gives him other weapons to use against progressive heart disease.

SEE YOUR DOCTOR. If at any time you find yourself wondering: "Is there something wrong with my heart?" . . . see your doctor at once.

If he finds your heart in good condition, an enormous load will be lifted from your mind. And if something should be wrong, your doctor's prompt diagnosis and treatment give you the best chance for living a long and normal life.

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories, Detroit 32, Michigan

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SUMMARY BY DISTRICTS

County Society	No. M.D.'s in* County	Members Dec. 31, 1946	Members Dec. 31, 1945	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District	298	240	246	—6	36	9	25	4	5
2nd District	175	148	150	—2	15	12	11	6	2
3rd District	165	141	142	—1	12	6	16	7	1
4th District	151	129	128	1	10	12	12	1	5
5th District	193	164	163	1	16	8	11	5	8
6th District	216	184	184		16	8	15	5	6
7th District	1033	875	781	94	94	112	54	20	26
8th District	260	212	214	—2	28	11	19	5	6
9th District	278	235	233	2	22	4	27	5	3
10th District	354	307	290	17	29	27	24	5	3
11th District	258	213	208	5	21	15	25	7	7
12th District	350	299	292	7	21	17	25	8	16
13th District	437	358	366	—8	44	19	32	10	9
Total	4168	3505	3397	108	364	260	296	88	97

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

Eight hundred ninety-two physicians received membership gratis in 1946 because of military service.

2. *County society programs.* Dr. Mitchell expressed the desire of the Vigo County Medical Society to have the same sort of programs that are being given at the Home Hospital in LaFayette. Dr. Clark said that organization of these courses has been hindered "by unavailable manpower more than anything else. However, we hope to be able to supply programs of this type in a great many places by next fall."

Legislative Matters

Dr. L. E. Burney, state health commissioner, reviewed briefly the eight bills that have been prepared and approved for submission to the 1947 Legislature. (Discussed by Drs. Ellison, Cameron, Portteus, and Oliphant).

Dr. J. T. Oliphant: I have been very pleasantly surprised at Dr. Burney's attitude. At no time has Dr. Burney had any movement on foot that he hasn't first taken to the doctors and has tried to assure them that first of all the State Board of Health is trying to transact its business and at the same time uphold the prerogatives of the doctors. Now, these district health departments are to aid the State Health Department. They have nothing whatever to do with the administration of local health affairs. The members of the State Board of Health who are physicians—Dr. Johns, Dr. Wyatt, and myself—have sat in very closely on this, with the determination that your rights and our own rights should be protected always, and I think they have been. I think Dr. Burney has done everything humanly possible to let the profession know about it. Heretofore the federal government has furnished too much money to our State Board of Health and that has given them the right to say too much about how it should be expended. For this reason we are asking for three times our existing appropriation, and when the EMIC program runs out six months after the cessation of hostilities we will be in a fair way to expend our own money and say what we are doing.

Dr. N. M. Beatty, co-chairman of the Committee on Public Policy and Legislation, discussed additional bills that are to be introduced in the Legislature.

New Business

1. *Contract with Editor of* THE JOURNAL, prepared by the attorney of the association, signed by Dr. Mitchell, chairman of the Council, and Dr. Shanklin, editor of THE JOURNAL.

2. *Nominations for Editorial Board* were deferred until the April meeting of the Council.

3. *April meeting of Council.* On motion of Dr. Hauss, the next meeting of the Council will be held on April 13, 1947.

Dr. J. E. Ferrell: I would like to say one thing. One of our biggest problems is getting doctors, young and old, to go out into rural communities to practice. A number of suggestions have been made. Primarily I am of the opinion that our educational system should be revamped to a certain point which would encourage men to take up the practice of rural medicine. Of course the hospital situation is a very strong factor in this respect. It is imperative that we devise some way to get men interested in rural practice.

Dr. H. G. Hamer, delegate to the American Medical Association, reported on the actions and discussions of the House of Delegates of the A.M.A. at its December 9-11, 1946 meeting.

Scholarships For Medical Students

Dr. Beatty offered the following resolutions which were adopted on motion of Dr. Clark, seconded by Dr. Kennedy:

WHEREAS, The Indiana State Medical Association is doing everything possible to aid in rendering the best medical service to the people of Indiana, and

WHEREAS, There is a shortage of doctors, particularly in rural areas of the state, and

WHEREAS, The Indiana State Medical Association already has and is co-operating with the Indiana State Board of Health in a program which will make modern hospital facilities more available to the people of the state, and

WHEREAS, It is necessary, in order to interest more young men and women in studying medicine and in practicing in Indiana, that the state maintain its medical school at the highest possible level, the Indiana State Medical Association at its annual meeting in October passed a resolution urging Indiana University to transfer the first year of medicine from Bloomington to Indianapolis and urged that a full-time dean of the medical school be employed.

Therefore Be It Resolved, That the Indiana State Medical Association, through its Council, hereby authorizes its president to appoint a committee to be known as the Committee on Medical School Scholarships, that the president shall appoint four of the association members interested in medical education and that in addition to these the committee shall consist of the following ex-officio members: the president of the association, chairman of the Council, and the co-chairmen of the Committee on Public Policy and Legislation.

Be It Further Resolved, That the Council hereby appropriates the sum of $3,000 per year which shall be used at the discretion of the committee for financing six (6) scholarships the recipients of which each to receive $500 per year and also is hereby authorized to accept donations from other sources for the purpose of adding additional scholarships on the same terms and under the same conditions.

Be It Further Resolved, That the Committee on Medical Student Scholarships shall co-operate with the press and other agencies in the finding and selection of recipients of these scholarships, that the recipients shall be students who are unable to finance their own medical education, that the recipients shall contract with the committee, after receiving their medical school education and one year's general internship, that they will be available for private practice in those communities which, in the opinion of the committee, additional medical service is most urgently needed.

Be It Further Resolved, That no recipient of an Indiana State Medical Association scholarship shall continue to receive the benefits of such scholarship unless he maintains a scholastic standing satisfactory both to the medical school and the scholarship committee.

(The second resolution above contains the amendment suggested by Dr. Hauss authorizing the committee to receive funds from other sources for the purpose of adding additional scholarships).

Dr. Romberger, president, appointed the following Committee on Medical School Scholarships: Chairman, C. J. Clark, Indianapolis; N. K. Forster, Hammond; M. R. Lohman, Fort Wayne, and Herman T. Combs, Evansville.

Executive Session

1. *Increase in salaries.* The Council voted to increase the salaries of the executive secretary and the headquarters and JOURNAL office personnel, effective January 1, 1947.

2. *Elections for 1947.*

a. *Executive Committee members.* Upon the motion of Dr. Clark, Dr. C. H. McCaskey was re-elected for 1947. Upon the motion of Dr. Black, Dr. Walter L. Portteus of Franklin was elected a member of the Executive Committee for 1947.

b. *Chairman of the Council.* Upon the motion of Dr. Hauss, seconded by Dr. Dodds, Dr. Alfred Ellison was elected chairman of the Council for 1947.

There being no further business, the meeting was adjourned.

RAY E. SMITH,
Executive Secretary.

BUREAU OF PUBLICITY

December 30, 1947.

Present: H. G. Hamer, M.D., chairman; Thomas A. Hendricks, executive secretary emeritus, and Ray E. Smith, executive secretary.

News release on 1947 officers and committees of the association for Indianapolis dailies was approved.

The following "Hints on Health" news releases were approved:

Week of January 6, 1947—"Lunch Box Nutrition."

Week of January 13, 1947—"Chronic Diarrhea."

Week of January 20, 1947—"Shingles."

A news release submitted by the Indiana Study of Child Health Services, which will be sent out by the State Board of Health, was approved.

BUREAU OF PUBLICITY

January 20, 1947.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

The following news releases for daily and weekly newspapers were approved:

A.M.A.-NBC dramatization of Dr. John Stough Bobbs over radio on January 25, 1947.

Social Hygiene day, February 5, 1947.

The following "Hints on Health" releases for weekly newspapers were approved:

Week of January 27, 1947—"Care of the Kidneys."

Week of February 3, 1947—"Postnasal Discharge."

Week of February 10, 1947—"Causes of Dropsy."

Two hundred copies of a booklet entitled "Check and Double Check on Sickness Insurance," issued by the Medical Society of the State of New York, were ordered for distribution to Indiana high school debate teams.

LOCAL SOCIETY REPORTS

100 PER CENT IN PAYMENT OF 1947 DUES

Benton County
Crawford County
DeKalb County
Fountain-Warren County
Fulton County
Hamilton County
Hancock County
Hendricks County
Jackson County
Pike County
Scott County

COUNTY MEDICAL SOCIETY OFFICERS

ADAMS COUNTY MEDICAL SOCIETY
President, Benjamin E. Duke, Decatur,
Vice-President, Harold F. Zwick, Decatur,
Secretary-Treasurer, John C. Carroll, Decatur.

CLARK COUNTY MEDICAL SOCIETY
President, Harry H. Reeder, Jeffersonville,
Vice-President, Mallory P. Weems, Jeffersonville,
Secretary-Treasurer, Joel T. Carney, Jeffersonville.

DEKALB COUNTY MEDICAL SOCIETY
President, Harry M. Covell, Auburn,
Vice-President, Charles I. Weirich, Butler,
Secretary-Treasurer, P. P. Reynolds, Garrett.

DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY
President, Dr. Thomas R. Owens, Muncie,
Vice-President, William Deutsch, Muncie,
Secretary, Joseph H. Clevenger, Muncie,
Treasurer, William J. Molloy, Muncie.

FOUNTAIN-WARREN COUNTY MEDICAL SOCIETY
President, Lee J. Maris, Attica.
Vice-President, Byron J. Smith, Kingman.
Secretary-Treasurer, John E. Fisher, Attica.

HENRY COUNTY MEDICAL SOCIETY
President, Chester A. Marsh, Hagerstown,
Vice-President, Benjamin L. Harrison, New Castle,
Secretary-Treasurer, Robert D. Spindler, New Castle.

KOSCIUSKO COUNTY MEDICAL SOCIETY
President, Harry A. P. Leininger, Warsaw,
Secretary-Treasurer, Harry A. Bishop, Claypool.

MIAMI COUNTY MEDICAL SOCIETY
President, H. E. Rendel, Mexico,
Vice-President, F. M. Lynn, Peru,
Secretary-Treasurer, Ralph E. Barnett, Peru.

PERRY COUNTY MEDICAL SOCIETY
President, N. A. James, Tell City,
Vice-President, Earl R. Snyder, Troy,
Secretary-Treasurer, David A. Dukes, Tell City.

PUTNAM COUNTY MEDICAL SOCIETY
President, Frederick R. Dettloff, Greencastle,
Secretary-Treasurer, James B. Johnson, Greencastle

RUSH COUNTY MEDICAL SOCIETY
President, W. H. Nutter, Rushville,
Secretary-Treasurer, K. F. Corpe, Rushville.

ST. JOSEPH COUNTY MEDICAL SOCIETY
President, Harold D. Pyle, South Bend,
Vice-President, Merle E. Whitlock, Mishawaka,
Secretary-Treasurer, Kenneth L. Olson, South Bend.

STEUBEN COUNTY MEDICAL SOCIETY
President, Marion M. Crum, Angola,
Vice-President, G. N. Lake, Pleasant Lake,
Secretary-Treasurer, Knight L. Kissinger, Angola.

VIGO COUNTY MEDICAL SOCIETY
President, Stephen C. Bradley, Terre Haute,
Vice-President, William O. Baldridge, Terre Haute,
Secretary-Treasurer, Albert M. Mitchell, Terre Haute.

WELLS COUNTY MEDICAL SOCIETY
President, Truman E. Caylor, Bluffton.
Vice-President, H. Brooks Smith, Bluffton.
Secretary-Treasurer, Thomas O. Dorrance, Bluffton.

WHITE COUNTY MEDICAL SOCIETY
President, J. P. Galbreth, Burnettsville,
Vice-President, H. B. Gable, Monticello,
Secretary-Treasurer, Henry W. Greist, Monticello.

Benton County Medical Society members held a dinner meeting, in Fowler, on January twenty-sixth. Following the dinner a business meeting was held. Nine members and their wives were present.

* * *

Boone County Medical Society members met on January seventh at the Witham Memorial Hospital, in Lebanon. The seventeen members present heard Dr. James E. Engeler, of Lafayette, discuss "Tinea Capitis."

* * *

Dearborn-Ohio County Medical Society members held their annual guest dinner meeting on December twelfth, at the Dearborn Country Club, in Aurora. Twenty-seven members and guests were in attendance.

On January twenty-third, the members again met at the New Reagan Hotel, in Lawrenceburg, to hear a discussion of the Indiana Blue Cross Hospitalization and Mutual Medical Insurance, Inc. Twelve members were present at this meeting.

* * *

Delaware-Blackford County Medical Society members held a meeting at the Hotel Roberts, in Muncie, on January twenty-first. Dr. Ramon A. Henderson, of Muncie, gave a report of the Secretaries' Conference. Officers for 1947 were elected. Thirty-eight members were in attendance at this meeting.

* * *

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on January second. The forty-two members present heard Dr. Carlo S. Scuderi, of Chicago, discuss "Treatment of Bone Defects."

* * *

Floyd County Medical Society members held a dinner meeting at the Country Club, in New Albany, on January tenth. Dr. Glenn W. Bryant, of Louisville, conducted a round-table discussion on "Obstetrical Analgesia and Anesthesia." Twenty-one members were present.

* * *

Fort Wayne (Allen County) Medical Society members met in the Chamber of Commerce Building, in Fort Wayne, on January seventh. The guest speaker was Dr. Dan L. Urschel, of Mentone, whose subject was "Brucellosis." Sixty-five members attended the meeting.



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Fountain-Warren County Medical Society members held a meeting in Mudlavia, on January twenty-third. The twelve members present discussed current business matters.

* * *

Greene County Medical Society members met at the Freeman Greene County Hospital, in Linton, on January sixteenth, for their regular business meeting. Eleven members were in attendance.

* * *

Howard County Medical Society members held a meeting at the Duke Restaurant, in Kokomo, on January third. The twenty-nine members present discussed current business matters.

* * *

LaPorte County Medical Society members held a dinner meeting on January sixteenth at Wildwood Inn, in Michigan City. This was a combined meeting of physicians, dentists and auxiliary members. The program was conducted by the LaPorte High School Debating Teams, whose subject for debate was "That a Complete Medical Service be Provided for All by the Federal Government."

* * *

Lawrence County Medical Society members met at the Dunn Memorial Hospital, at Bedford, on January eighth. The guest speaker was Dr. Dillon Geiger, of Bloomington, whose subject was "The Use of Sulfonamides and Penicillin in Ear, Nose and Throat Problems in General Practice." Seventeen members attended the meeting.

* * *

Montgomery County Medical Society members held a dinner meeting on January seventeenth, at the Culver Hospital, in Crawfordsville. The speaker of the evening was Dr. Frank B. Ramsey, of Indianapolis, who gave a report on the recent meeting of the American College of Surgeons. Twenty-eight members and two guests attended the meeting.

* * *

Madison County Medical Society members held a joint meeting with the Bar Association at the Country Club, in Anderson, on January twenty-second. Dr. Leroy E. Burney, of Indianapolis, was the guest speaker, choosing as his subject "Proposed Medical Legislation." The meeting was attended by seventy-five doctors and lawyers.

* * *

Owen-Monroe County Medical Society members held a meeting at the Graham Hotel, in Bloomington, on January thirty-first. Thirty members attended, and heard Dr. Cyrus J. Clark, of Indianapolis, speak on "Thiouracil."

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, in Clinton, on January fifteenth. The guest speaker of the evening was Dr. Robert M. Vandivier, of Indianapolis, whose subject was "Undulant Fever and Non-specific Diseases of the Chest." Fifteen members were present.

* * *

Putnam County Medical Society members held a meeting in Greencastle, on January ninth. The twelve members in attendance heard Dr. Robert M. Vandivier, of Indianapolis, discuss "Diseases of the Lungs."

* * *

Randolph County Medical Society members met on January thirteenth, at the Randolph County Hospital, in Winchester. Dr. Leo E. Jordan, of Lynn, President of the Society, outlined the program for the coming year. Sixteen members were in attendance.

* * *

Rush County Medical Society members met in Rushville, on January tenth, for their regular business meeting and election of officers for 1947. Nine members were present.

* * *

St. Joseph County Medical Society members held a meeting at the Indiana Club, on January fourteenth. The guest speakers were Dr. Eli Rubens, of South Bend, and Dr. Ben J. Siebenthal, of South Bend, who discussed "Immunization Procedures in Children." The meeting was attended by sixty-two members and seven guests.

* * *

Shelby County Medical Society members met in Shelbyville, on January eighth. The twenty-one members present heard Dr. David L. Adler, of Columbus, discuss "Tropical Diseases and Experiences in the Tropics."

* * *

Vanderburgh County Medical Society members met at Hotel McCurdy, in Evansville, on January fourteenth. The guest speaker for this meeting was Dr. Ralph A. Kinsella, of St. Louis, Missouri, who presented a paper on "The Pneumonias." Sixty-two members were present.

* * *

Wayne-Union County Medical Society members held a meeting on January ninth, in Richmond. Dr. Robert E. Pumphrey, of Dayton, Ohio, was the guest speaker, and chose as his subject "Diagnosis and Treatment of Common Rectal Disorders." Twenty-three members were in attendance.

* * *

Whitley County Medical Society members held a dinner meeting at the "30" Club, in Columbia City, on January fourteenth. A general medical discussion followed the dinner. Eight members attended this meeting.

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[1]Human Fertility 10: 25 (Mar.) 1945.

[2]Warner, M. P.: J.A.M.A. 115: 279 (July 27) 1940.

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WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Recording Secretary—Mrs. J. L. Allen, Greenfield.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. O. H. Bakemeier, Indianapolis.

Woman's Auxiliary Board Meeting
April 22, 1947,
Indianapolis Athletic Club.
Dinner at 6:30 p.m.
Guest—Mrs. Jesse D. Hamer, Phoenix, Arizona, National President.

Convention of the House of Delegates,
April 23, 1947,
Columbia Club, Indianapolis.
9:30 a.m. Business session. Mrs. S. J. Petronella, presiding.
Guest speaker, Mrs. Jesse D. Hamer.
12:00 noon Luncheon.
1:00 p.m. Business session continued.
(Watch for further information regarding meeting.)

Bulletin Number One

Haddon Hall will be headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 9-13, 1947.

Requests for reservations should be sent immediately to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.

The following News Letter has been received from the Woman's Auxiliary to the American Medical Association:

Conference

The third annual Conference of State Presidents, Presidents-Elect and National Chairmen of Standing Committees was held in Chicago in December. The attendance was most gratifying, and many constructive ideas and suggestions will be found in the December issue of *The Bulletin*. Several recommendations were made:

1. It was recommended that the names of the presidents-elect of state auxiliaries be placed on the mailing lists of the national officers and chairmen of standing committees, so that in the future presidents-elect will receive the programs of national committee chairmen.
2. It was recommended that the state presidents make known to the officers, committee chairmen and other working members of their auxiliaries that much of the information needed by auxiliary workers appears in *The Bulletin*.
3. It was recommended that state and county auxiliaries sponsor only such speakers as are recommended by the American Medical Association and state and county medical societies. State presidents are asked to advise their county auxiliaries of this recommendation.
4. It was recommended that the resolution passed at the 1940 meeting, which provided for "state presidents to report briefly, not to exceed TWO minutes, any auxiliary accomplishment," be adhered to.

Atlantic City Meeting

The twenty-fourth annual meeting will be held in Atlantic City, June 8-12, 1947, with headquarters at Hotel Haddon Hall. On Sunday, June 8, there will be a tea in honor of the president; the House of Delegates will meet on Tuesday and Wednesday, with a luncheon each day, and the auxiliary dinner will be held Thursday night. Meetings of the Board of Directors will be on Monday and Thursday.

The hotel situation is still critical and room reservations should be made IMMEDIATELY through the subcommittee on hotels, Dr. Robert Bradley, chairman, 16 Central Pier, Atlantic City, New Jersey. State presidents are asked to inform their members and to urge them to make hotel reservations AT ONCE. This is very important as many of the hotels are booked to capacity. A list of the hotels, with rates and an application blank, will be found in the October 26 issue of the *Journal of the American Medical Association*.

December Bulletin

The December *Bulletin* will be in the mail the first week in February. Information regarding hotels will also be in the December *Bulletin*.

Margaret N. Wolfe,
Executive Secretary.

Cass County

The Cass County Auxiliary held its February meeting in Logansport, on Friday, February twenty-first, when Mrs. S. J. Petronella, the state president, was the guest speaker.

Delaware-Blackford County

The Woman's Auxiliary held a general business meeting at the home of Mrs. O. W. Owens, on January twenty-first. Scrapbooks for the Harry Mock School were made. Mrs. William J. Quick, president, presided. The Auxiliary reports a membership of fifty-eight.

Marion County

Mrs. S. J. Petronalla was a special guest of the Auxiliary on January twenty-first at the first meeting of the year, which began with a luncheon, followed by a business meeting and bridge at the Marott Hotel. While in Indianapolis Mrs. Petronella, assisted by Mesdames Frank Gastineau, Charles Voyles, E. B. Lamb, and O. H. Bakemeier, made arrangements for the House of Delegates meeting which will be held in Indianapolis, April twenty-second and twenty-third. Mrs. Jesse D. Hamer, of Phoenix, Arizona, National President of the Woman's Auxiliary to the American Medical Association, will be a special guest.

Vanderburgh County

Mrs. A. W. Ratcliffe, of Evansville, president-elect of the Woman's Auxiliary to the Indiana State Medical Association, attended the meeting of the Woman's Auxiliary to the American Medical Association, at the Continental Hotel, in Chicago, in December. The meeting is held each year in December for presidents and presidents-elect of State Auxiliaries.



The sick or injured patient is almost simultaneously subjected to two traumas—the basic pathologic process and tissue malnutrition—for malnutrition almost always begins "as soon as injury or disease occurs."[1] Recognition of the vitamin depleting role of dietary restrictions, increased metabolism, glucose infusions, and impairment of absorption, has brought with it the realization that vitamins must be administered in therapeutic—not maintenance—dosages when multiple deficiencies complicate disease. Upjohn provides a full range of maintenance and therapeutic vitamin preparations for oral and parenteral administration.

1. J.A.M.A. (April 22) 1944

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News Notes

Dr. James S. McElroy, of New Castle, has been notified recently of his selection for membership in the American Board of Surgery.

Dr. Charles P. Anderson, Medical Director of the Gary Public Schools, has resigned to accept a job with the Wayne County Health Department, at Detroit, Michigan. Dr. Mattie J. Bullard, who was acting director of the medical department during the war years, will return to Gary to assume charge of the school health program.

After three and one-half years' service in the Army, Dr. A. Ebner Blatt has opened an office for the practice of internal medicine at 3209 North Meridian Street, in Indianapolis.

Dr. Warren Baker, formerly of Westville, has announced the opening of an office in the Warren Building, in Michigan City. Dr. Baker will specialize in surgery and diseases of the eye.

Announcement has been made by Dr. Lyman D. Eaton, formerly of Evansville, of the opening of an office in the Star Building, in Franklin, for the general practice of medicine and surgery.

Having recently completed his residency at the Methodist Hospital, in Indianapolis, Dr. W. L. Donham has opened an office at 715 North Main Street, Bicknell.

The following Indiana surgeons were received into fellowship in the American College of Surgeons at the convocation on December 20, 1946, during the clinical congress in Cleveland: Drs. Cah T. Bowers, Fort Wayne; Theodore J. Bruegge, Kokomo; Merrill S. Davis, Marion; Henry W. Eggers, Hammond; C. Basil Fausset, Indianapolis; Frederick A. Loop, Lafayette; George A. May, Madison; James S. McElroy, New Castle; Richard H. Miller, Fort Wayne; Robert A. Royster, Evansville; Victor A. Teixler, Indianapolis.

Dr. Keith T. Meyer, of Evansville, has opened an x-ray laboratory in Suite 104, Cadick Apartments. Doctor Meyer served for seventeen years as radiologist at the Deaconess Hospital, in Evansville.

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons, announces a foundation prize contest. For further information write Dr. James R. Bloss, secretary, 418 Eleventh street, Huntington 1, West Virginia.

Dr. Frederic G. Perry, formerly of Plymouth, has announced his affiliation with the Duemling Clinic, in Fort Wayne, where he will specialize in dermatology.

Announcement has been made by Dr. R. W. Phares of the opening of an office at 905 West Mulberry Street, Kokomo, for the general practice of medicine.

Dr. John W. Ripley, who has recently been released from service, has announced the opening of an office at 208½ South Chestnut Street, Seymour, for the general practice of medicine. Doctor Ripley served for two years in the army medical corps, and at the time of discharge had attained the rank of Captain.

Northern Tri-State Medical Association

The seventy-fourth annual meeting of the Northern Tri-State Medical Association will convene in the Rackham Memorial Educational Building, in Detroit, Michigan, on April eighth. Registration is scheduled for 8:30 a.m., and the speakers for the morning include Dr. Winfred B. Harm, Detroit; Dr. William M. Tuttle, Detroit; Dr. J. W. Conn, Ann Arbor; Dr. Sprague H. Gardiner, Indianapolis; Dr. William Magner, Toronto. The luncheon speaker will be Dr. George F. Lull, of the American Medical Association, Chicago. The afternoon speakers are Dr. Frederick A. Coller, Ann Arbor; Dr. Laurence H. Snyder, Columbus, Ohio; and Dr. Edward D. Spalding, Detroit.

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Indianapolis Obstetrical and Gynecological Society

On January twenty-second a group of Indianapolis obstetricians and gynecologists met in the auditorium of St. Vincent's Hospital and organized the Indianapolis Obstetrical and Gynecological Society. The charter members consisted of the following twenty-one active and five honorary members:

Honorary Members: H. F. Beckman, A. S. Jaeger, Walter Kelly, Jane Ketcham, John A. Pfaff.

Active Members: Don D. Bowers, Lawson J. Clark, Sprague H. Gardiner, Charles F. Gillespie, Ross E. Griffith, G. W. Gustafson, Carl Habich, J. H. Hawk, J. William Hofmann, Carl P. Huber, Foster J. Hudson, John F. Kelly, Edward C. Lidikay, C. O. McCormick, C. O. McCormick, Jr., A. J. Micheli, Ben B. Moore, Dudley A. Pfaff, David L. Smith, John F. Spahr, Dan E. Talbott.

The following officers were elected: C. O. McCormick, president; Carl Habich, vice-president; and Lawson J. Clark, secretary-treasurer.

The object of the Society is to promote knowledge in all that pertains to the practice of obstetrics and gynecology, and to foster a closer relationship between the two specialities. The active membership is limited to fifty members.

A candidate for membership must be a graduate of a class A medical school, a member of his local medical society, his state society and the A.M.A. He must have been a graduate of medicine for at least five years, and shall present evidence of his interest or training in obstetrics and/or gynecology. Upon application he must present a thesis on a subject relative to obstetrics or gynecology.

Any qualified physician practicing in Indiana is eligible for membership. The initiation fee is $5.00, and the annual dues is $10.00.

The Society is to hold three regular meetings each year, one in January, one in April, and one in October.

The inaugural meeting will be held Wednesday evening, April ninth, at the Indianapolis Athletic Club. It will be a dinner-guest meeting. The speaker will be Dr. Frederick H. Falls, of Chicago, Head of the Obstetrical and Gynecological Department of Illinois University. His address will be an illustrated talk upon "Ectopic Pregnancy—Its Etiology, Diagnosis and Treatment."

The number of dinners to be served is limited to 100. Early reservations will be appreciated—"First come, first served." The price is $5.00 and a check must accompany the reservation. Those wishing to make dinner reservations or application for membership will please write Dr. Lawson J. Clark, Secretary, 420 Hume Mansur Building, Indianapolis.

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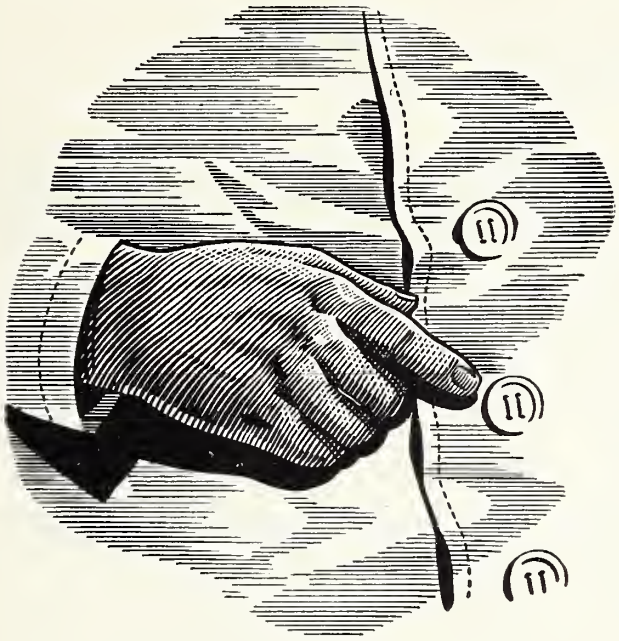
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THE COMPLICATIONS OF CRANIOCEREBRAL INJURIES

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Chicago

FORTUNATELY the majority of patients who sustain a cranio-cerebral injury make an uneventful and complete recovery regardless of the nature of the treatment. The essentials of good treatment of such cases are few. Rest is the most important factor. How much rest is advisable in the individual case will depend upon the severity of the injury and the nature of the patient's symptoms. This phase of the treatment, like all others, must be adjusted to the needs of the individual case. It is important that the patient receive an adequate diet and sufficient fluids. Dehydration of any patient, including those whose heads have been injured, is potentially dangerous. In general, more harm than good has been done by dehydration in cases of cerebral injury. The attending physician must never forget the fact that it is impossible to dehydrate the brain without at the same time extracting much-needed fluids from all other parts of the body. In other words, it is impossible to dehydrate only the brain; one of necessity must dehydrate the patient. For that reason the use of hypertonic fluids, both by mouth and intravenously, has gradually fallen into disuse in the majority of neurosurgical clinics in this country today. The intravenous injection of 50 per cent glucose or sucrose has no place in the treatment of the ordinary case of injury to the head. It is seldom of any value, and then only as an emergency measure to tide the patient over until something more permanent, such as a surgical decompression, can be done. Whether one does lumbar punctures in every case, a totally unjustifiable procedure, or reserves this useful means of treatment or of obtaining useful information to those cases in which it is indicated, is a matter of secondary importance.

The most important single factor in the care of victims of craniocerebral trauma is constant and intelligent observation—observation to detect the development of complications at the earliest possible time so that proper treatment may be effective. What are the complications and what must one look for? The most common complications are intracranial hemorrhage and intracranial infection. The manifestations which one must constantly look for are: (1) impairment of consciousness; (2) alterations in the pulse rate, respiratory rate, and the blood pressure; and, (3) the development of fever.

In a patient who has sustained an injury to his head his state of consciousness is the most important single thing to watch. His state of consciousness will usually change before there are any other evidences of an intracranial complication. The patient who was bright and alert or merely somewhat cooperative, and who later slips first into a state of lethargy and then stupor, and if left untreated, into coma, is suffering from a gradually developing cerebral impairment probably as the result of cerebral compression. Similarly the patient who has been admitted in coma and who remains in coma may well be suffering also from cerebral compression and that possibility should be investigated. Changes in the blood pressure, pulse, and respiration commonly follow long after the changes in the state of consciousness have appeared. Alterations in these vital signs may appear only terminally.

HEMORRHAGE

Intracranial hemorrhage is the most common type of complication of craniocerebral trauma and

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the most important from the standpoint of treatment. Such hemorrhages may take several forms.

Intracerebral hemorrhage is relatively common with cerebrovascular disease and with arterial hypertension, but is rare as the result of trauma. It may occur but is seldom recognized prior to operation or autopsy. It is usually mistaken for the much more common epidural and subdural hemorrhages. When found, at operation, the hematoma should be evacuated. If the damage to the substance of the cerebral hemisphere has not been too severe recovery may be nearly complete. Such is often the case.

Subarachnoidal hemorrhage, on the other hand, is the most common type of posttraumatic intracranial hemorrhage. The subarachnoidal space lies between the two layers of the leptomeninx, the pia mater, and the arachnoid, immediately over the surface of the brain. It contains the cerebrospinal fluid. Any bleeding into this space is, therefore, into this fluid. The blood mixes intimately with the fluid and is soon spread over the surface of the entire central nervous system. As the blood vessels from which such hemorrhage can come lie in the pia mater, and as this fine membrane is closely applied to the surface of the brain, blood in the subarachnoid space generally means a laceration of this membrane and a contusion and laceration of the surface of the brain. Usually it is not possible to determine the location of this contusion and laceration clinically, but in some instances focal neurological signs such as paralysis or localized convulsions indicate the location of the cerebral damage.

However, even in those cases where no localizing symptoms exist the subarachnoidal hemorrhage itself gives rise to a typical and diagnostic clinical picture. Fresh blood in the subarachnoidal space commonly gives rise to little in the way of symptoms unless it is present in very great quantities. In approximately twenty-four hours, however, the red blood cells begin to disintegrate. They discharge their hemoglobin into the cerebrospinal fluid, and at the same time the larger protein molecules break down into smaller ones. This material in the cerebrospinal fluid is irritating. The patient therefore develops the symptoms of meningeal irritation, comparable to those of meningitis. In fact, the patient has a meningitis, albeit a sterile one. He complains of increasing headaches. He has a stiff neck. He may become somewhat lethargic and confused, or in some cases even delirious. He is often nauseated and may vomit. He usually has a fever, which seldom rises above 102, and is usually in the range between 99 and 101. All of these manifestations tend to be much more severe in children than they are in adults. Occasionally the clinical picture in a child may be such as to alarm gravely both the parents and the physician. The condition may be mistaken for an actual pyogenic meningitis.

Fortunately the diagnosis and treatment are simply achieved by one means—a spinal puncture. This is one condition in which that procedure is definitely indicated. It serves to diagnose the subarachnoid hemorrhage and by an examination of the fluid to exclude an infection. It also serves to relieve the patient of much of his discomfort. Why this should be true is not clear, but the fact can not be denied. It is obvious that with blood spread throughout the two hundred or so cubic centimeters of cerebrospinal fluid it is impossible to hope to remove all of the blood by removing 10 to 15 cc. of fluid by lumbar puncture. Yet the relief is immediate and dramatic. It may not persist, and for that reason the lumbar puncture may have to be repeated. When it should be repeated and how frequently will have to be determined by the clinical manifestations in each individual case. The operator should be warned not to use the same needle-hole in the skin repeatedly, as by this means he may introduce pyogenic organisms into the spinal fluid and change a sterile meningitis into an infectious one. Usually the blood in the fluid rather rapidly disappears and the symptoms subside. Naturally if the contusion and laceration of the brain, associated with the subarachnoidal hemorrhage, are severe and give rise to symptoms, these will not be relieved by removal or absorption of the blood from the subarachnoidal space.

Subdural hematomas involve the space just outside of the arachnoid, between it and the dura mater. These are of three types, the acute, subacute, and chronic.

Acute subdural hematomas are not common. They consist of a collection of blood in the subdural space which accumulates rapidly and gives rise to symptoms of cerebral compression shortly after the injury. The bleeding is usually from tearing of the cortical veins which cross from the cerebral hemisphere to the superior longitudinal sinus. Ordinarily it is not possible to find the bleeding points and as a result such rapidly developing hematomas in the subdural space are usually fatal in a short time.

Subacute subdural hematomas develop more gradually over several days of time. The blood may come from the cortical communicating veins noted above, or may arise from extensive contusion and laceration of the cerebral surface with tearing of the vessels of the surface of the brain and of the leptomeninx. In these cases the patient usually becomes less and less responsive and may develop symptoms of compression of one cerebral hemisphere, such as a hemiplegia, an aphasia, or a disturbance in the visual field. The pulse and respiratory rates often gradually become slower and the blood pressure may occasionally rise. However, diagnosis should never wait upon the development of such changes in the vital signs. Not infrequently the third cranial nerve on the side of the hematoma will be compressed by herniation of the uncus through the incisura of the tentorium cere-

belli. This will result in a dilatation of the pupil on that side, a failure of that pupil to respond to light, and in severe cases a ptosis of that upper eyelid and paralysis of the extra-ocular muscles supplied by that oculomotor nerve. Although such ocular findings, when present, commonly indicate the side of the hematoma, they can not be relied upon as absolutely diagnostic. On one occasion when I was called upon to operate for a subdural hematoma, I found a man with a left hemiplegia and a dilated, fixed right pupil. Naturally a right subdural hematoma was suspected. Exploration of the right side was negative but a large hematoma was found on the left side and evacuated. In all probability such confusing symptoms arise as the result of displacement of the opposite cerebral peduncle against the edge of the tentorium and against the third nerve. Occasionally the first symptom of such a subacute subdural hematoma may be a convulsive seizure. Several years ago a man sixty years of age was admitted to my service following a fall from a cart to the pavement about five feet below. He sustained a basal skull fracture from which he made a prompt and satisfactory recovery with no treatment other than rest. He was allowed out of bed two weeks after the injury and a few days later he was up and about the ward feeling well. He was seen and examined about 8:00 A.M. one morning seventeen days after the accident, and told that he might go home that day. At 10:00 A.M. I received an urgent message to come to the ward at once. This patient had just had a generalized convulsion. A spinal puncture a short time later revealed an increased pressure in the cerebrospinal fluid of 300 mm. of water. He was shortly taken to the operating room and subdural hematomas evacuated from the space over the cerebral hemispheres on both sides. He has had no trouble since.

Chronic subdural hematomas have been commonly recognized only during the past twenty years, yet they are one of the commonest of intracranial lesions. They are probably all traumatic in origin although the responsible physical injury can not always be identified. Although these hematomas may follow severe cranial injuries, they may also follow what appear to be trivial ones. One patient who subsequently developed a chronic subdural hematoma merely raised from a stooped position and struck his head on the under surface of a drawer. Another patient, a butcher, had a small meat-hook fall and strike him on the top of the head. Many of these patients are chronic alcoholics, although by no means all of them. They also tend to fall into two age groups, the young infants and adults past middle age. Adolescents and young adults, in spite of the higher incidence of trauma, develop chronic subdural hematomas much less frequently. In the infants the responsible trauma is usually that of birth.

These lesions are not hematomas, strictly speaking. Rather they are hemorrhagic cysts. Bleeding occurs into the subdural space from small tears in the communicating cortical veins at the point where they are attached to the superior longitudinal sinus. However, the amount of blood is too small to give rise to any significant symptoms at that time. The bleeding soon stops but the blood remains in the subdural space as there is no outlet and no capillary bed by which it can be absorbed. The red blood cells soon begin to break down and discharge their hemoglobin into the serum. The larger protein molecules break down into more numerous smaller ones. As a result, the osmotic tension in the serum rises. This causes the passage of fluid from any neighboring blood vessels and from the cerebrospinal fluid in the subarachnoid space which lies on the other side of the thin arachnoid membrane. Thus the blood is gradually diluted and the size of the cyst slowly increases. It becomes encapsulated by fibroblasts which arise either from the leukocytes of the blood or from the meninges. As it slowly grows it gives rise to symptoms similar in many respects to those of a brain tumor. Headaches develop and are usually the outstanding symptom of the condition. The headaches are often even more severe and unremitting than those associated with intracranial neoplasms. It seems likely that the severity of these headaches may be accounted for in some measure by irritation of the sensory nerves in the meninges by the disintegrating blood. Nausea and vomiting may occur but are less common than with brain tumors, doubtless because the elevation of intracranial pressure is usually less marked. Papilloedema too may develop, but actually is present in only a small percentage of cases. It is notable that the findings on spinal puncture are apt to be misleading. In many cases the pressure is perfectly normal, or even less than average. In a few cases the fluid may be slightly yellow, when compared with distilled water; but in other instances it may appear normal. There are usually no cells in the fluid but the protein content may be somewhat elevated. Symptoms of local cerebral involvement may or may not be present. The most common of these are weakness of the extremities on one side and, when the left side of the brain is involved, disturbances of speech. The visual fields are only very occasionally implicated and then probably as the result of compression of the posterior cerebral artery by herniation of the uncus through the incisura of the tentorium. And sensory changes are much less common than motor ones. In many cases, however, persistent headaches are the only manifestation of the disease. Because of the manner in which these hemorrhagic cysts develop the symptoms commonly appear weeks or even a few months after the responsible trauma. Whenever a chronic subdural hematoma is strongly suspected trephine openings should be made in the skull bilaterally to confirm or deny the suspicion. This is a simple and relatively innocuous surgical procedure. If a subdural hemorrhagic cyst is found it may be possible to evacuate and wash it out sat-

isfactorily through one or two trephine openings. In other cases it may be necessary to make a subtemporal decompression or reflect an osteoplastic flap in order to remove satisfactorily all of the coagulated blood as well as the cystic fluid. The results of such surgical procedures are among the most gratifying in neurological surgery. It is not uncommon to have the stuporous or comatose patient arouse and talk while on the operating table.

Extradural hematomas were once looked upon as the most common and important of the traumatic intracranial hemorrhages, a position which we now know to be occupied by the subdural hematomas discussed above. Nevertheless, extradural hematomas are still of considerable importance. These accumulations of blood between the skull and dura mater usually arise from tears in the middle meningeal vessels. Very occasionally laceration of one of the dural sinuses, such as the superior longitudinal or the transverse, will give rise to an extradural hematoma. These tears in dural blood vessels are almost always associated with overlying fractures of the skull. Therefore, this is one of the few situations in which an x-ray examination of the skull is of importance in the treatment of a patient suffering from cranial trauma.

Extradural hemorrhages are usually the result of arterial bleeding. Therefore, the symptoms develop much more rapidly than do those of most subdural hematomas, the situation becomes critical much sooner, and prompt surgical intervention is most imperative. Several years ago a man approximately forty years of age was knocked down by an automobile in front of one of our neighborhood hospitals. The man was brought directly into the hospital suffering from a laceration of the scalp. He was fully conscious and rational. The intern, one of my former students, sutured the laceration. While he was taking care of the patient in the emergency room he noted that he was gradually becoming lethargic. He accordingly called me and arranged for the patient's immediate transfer to the hospital where I was working. On arrival there the patient was already stuporous. X-ray examination at the first hospital had disclosed a fracture through the temporal region. The patient was taken directly to the operating room and in less than two hours after the accident a large extradural hematoma was evacuated and the torn middle meningeal artery controlled. The development of symptoms is not always so rapid but the necessity for prompt action is always acute. Last winter I witnessed a most tragic occurrence. A healthy young girl, sixteen years of age, was riding her new pony one morning. He ran and threw her off so that she struck her head on a fence post. She was brought to an outlying hospital. She was perfectly conscious, alert and cooperative. She was put to bed. In the afternoon she became first sleepy, and then stuporous. However, the attending physician was not notified until she ceased breathing about 8:00 P.M. Artificial respiration was administered and she was given oxygen intranasally. I was called and was able to operate upon her about 11:30 P.M. A large extradural hematoma was found and evacuated. Unfortunately the cerebral compression had already become too severe and existed too long. Spontaneous respiration was never resumed and cardiac action soon ceased. Prompt recognition of what was taking place here most certainly would have altered the outcome. With extradural hematomas one frequently has no time to lose if the patient is to be saved.

Commonly these patients are injured and rendered briefly unconscious as the result of cerebral concussion. They then recover consciousness and may appear quite well. Their state of apparent well-being may be most deceptive. Another case will illustrate that point. An eight-year-old girl was knocked down by a truck about 10:00 A.M. She was taken immediately to a hospital. There was a small bruise on the head and an x-ray examination of the skull was made. No fracture was seen and the child was sent home. About four o'clock that afternoon her mother noted that the child seemed unduly sleepy. She called her busy family doctor who felt that the mother's fears were insignificant and engendered by her own apprehension. However, by 7:00 P.M. the child could be roused only with difficulty. A pediatrician was called. He found a semi-stuporous child with some disturbance of speech and a weakness of the right arm and leg. He immediately recognized that the child was suffering from an extradural hematoma and called me. We arranged for the child's transportation to the hospital where she was operated upon shortly after admission. I found a linear fracture of the left temporal bone with a tear in the middle meningeal artery directly beneath it. This had given rise to a large epidural hematoma. The blood was evacuated and the bleeding vessel coagulated. The child made a rapid and uneventful recovery. Later, examination of the x-ray films made at the other hospital shortly after the accident disclosed that they were of such poor technical quality that the fracture which was exposed at operation could be visualized only with great difficulty.

Not all victims of extradural hemorrhage have a period of mental alertness (known as the lucid interval) between the initial unconsciousness and the stupor and coma produced by compression of the brain by the accumulating blood. Some patients are so severely injured that they do not recover from the unconsciousness induced by the original cerebral concussion before it has merged with the stupor produced by the hematoma. Here we must be dependent upon less certain signs for the diagnosis. Whenever the coma resulting from a cranial injury becomes unduly prolonged the possibility of an extradural (or a subdural) hemorrhage must be entertained. If the patient has a fracture across the middle meningeal vessels or

one of the dural sinuses, particularly if the latter is depressed, the likelihood of such hemorrhage is even greater. If the patient develops a hemiplegia, or a unilateral dilated and fixed pupil, the possible hemorrhage becomes probable. The pressure of the spinal fluid is usually elevated with extradural hematomas, in contrast with the situation with many chronic subdural hematomas. However, spinal puncture in these cases must be done cautiously. If there is a definite third nerve involvement, as evidenced by the dilated fixed pupil and some immobility of the eyeball, or if the respiratory rate is slow or irregular, it is likely that the uncus has herniated through the incisura of the tentorium and a spinal puncture may prove fatal. In such cases a trephination of the skull in one or both temporal regions is a far safer procedure than a lumbar puncture. In any case in which an extradural or subdural hematoma is suspected it is far wiser to make bilateral burr holes in the skull in the superior temporal regions, under local anesthesia, than it is to let the patient grow steadily worse without such a simple investigation.

INFECTION

Infection is a much less common complication than is hemorrhage. Such infections as osteomyelitis of the skull, and brain abscess secondary to compound depressed fractures of the skull, and penetrating wounds of the brain, although a constant problem in military surgery, are fortunately of little concern in civilian practice. Those infections for which we must be on the alert are the pyogenic meningitides secondary to fractures through the paranasal sinus, the cribriform plates and the ears. Through such fractures infectious organisms may easily gain entrance to the intracranial cavity. It is most important that the possibility of the infection be recognized and every step taken which can prevent the development of such a complication. Fractures through the ears do not often give rise to trouble of this type unless a definite infection of the ears exists. Fractures in or near the nose, on the other hand, even though no sinusitis or coryza exists, may lead to a vicious meningitis. Whenever there is a discharge of cerebrospinal fluid from the nose, or much less commonly from the ears, we have direct evidence that an opening to the subarachnoid space exists. Such patients should be kept flat in bed with their head lower than their feet in order to encourage the outward flow of cerebrospinal fluid which will sweep infectious material out of the wound rather than in toward the meninges. If the patient sits up the intracranial pressure will fall below atmospheric pressure and material will be sucked into the intracranial cavity. If this material is infected a meningitis will probably follow. Similarly spinal punctures should not be done in such cases as that, too, will reduce the normal intracranial pressure and encourage the entrance of infection. The patient should be placed immediately upon adequate sulfonamide therapy, preferably with sulfadiazine which should be given intravenously if it is not possible for the patient to take the drug by mouth. Penicillin is probably not as satisfactory a prophylactic agent in such cases as it does not enter the cerebrospinal fluid in any considerable quantities when the meninges are normal. All patients with fractures in and around the nose and paranasal sinuses should also be placed on sulfonamide therapy even though there is no cerebrospinal rhinorrhea. Last spring I had a patient brought to me suffering from a pneumococcus meningitis who was already in a terminal condition. On Saturday he had fallen from a ladder and struck his nose. Apart from a moderate bloody discharge from the nose he had no symptoms. On Sunday he spent the day in his room in a rooming house. That evening he was found in his bed, moaning and unresponsive. A physician was called and he was taken to a nearby hospital. I was called to see him on Tuesday. He was comatose and had a temperature of 106(F). All of the symptoms of a meningitis were present. Examination of the spinal fluid revealed a milky fluid with over 20,000 polymorphonuclear leukocytes per cu. mm. The infectious organism was the pneumococcus. Unfortunately treatment had been too long delayed and in spite of intensive intravenous and intraspinal therapy with sulfadiazine, penicillin, and pneumococcus anti-serum the patient died the following day. Postmortem examination disclosed a fracture through the cribriform plates of the ethmoid bone.

When a meningitis does develop following cranial trauma treatment should be begun as promptly and as intensively as possible. Care should be taken to insure a high fluid intake. If, as so often happens, the patient is unable to take adequate fluids by mouth they should be administered by stomach tube, by vein, or subcutaneously. If an anemia develops blood transfusions should be freely resorted to. Sulfadiazine should be given by mouth or by vein in quantities sufficient to insure a blood level of 10 mgm. per cent or above. If the sulfadiazine is given by mouth it should be accompanied by bicarbonate of soda in equal or somewhat greater amounts. The urine should be carefully watched and if it is found to contain blood or sulfadiazine crystals the amount of fluids and alkali should be promptly increased and the sulfadiazine stopped. Penicillin should also be given. It should be administered intramuscularly at two- or three-hour intervals in amounts sufficient to insure the administration of 120,000 units or more in every twenty-four hours. It should also be given intraspinally for a few days. A lumbar puncture should be made and 30 to 40 cc. of fluid removed. Ten to 20,000 units of penicillin should be prepared in 20 cc. of normal saline and injected slowly into the spinal canal after the fluid has been removed. This may be done once or twice a day. Penicillin in the spinal canal is certainly irritating and, if given too often, in too large quantities, or over too long a period

of time it will provoke hemorrhages into the spinal fluid and may provoke a hyperplastic fibrotic process in the meninges which later may prove serious.

Other complications of cranial injury, such as chronic cerebrospinal rhinorrhea, spontaneous introduction of air into the ventricular system, osteomyelitis of the skull, epilepsy from cerebromeningeal scars, depressed fractures of the skull, decerebrate states, et cetera, may occur. Most of them are quite rare, whereas the complications discussed above are common and are furthermore the ones which appear suddenly, which must be promptly recognized, and appropriately treated if the patient is to survive.

THE SIGNIFICANCE OF CHANGES IN THE FEMALE BREAST

CLEON A. NAFE, M.D.*

INDIANAPOLIS

AS a result of much publicity concerning cancer during the last few years, women are more conscious of abnormal conditions of their breasts, and more frequently seek advice from their physicians concerning what should be done about a lump, pain, discharge from the nipple, and other symptoms. They are usually concerned about the dangers of cancer. In order to give the proper advice the physician must have a clear conception of pathological changes in breasts and their significance.

Unfortunately, there has been much confusion concerning the causes of breast changes, there has existed a great variety of terms to designate these changes, and there has been a wide difference of opinion among pathologists in the interpretation of these changes, particularly in their casual relationship to malignancy.

With the development of the science of endocrinology there has resulted a clearer understanding of factors that control breast changes. Now it is generally agreed that the changes in the breast are mainly brought about by hormones, with those elaborated in the ovaries exerting the main controlling influence, while others, probably from the pituitary, placenta, and adrenal cortex play a minor part.

The confused nomenclature is bewildering, and as time goes on there is no improvement in this regard. Every now and then an author of a new book adds a new list of terms to the already large number. It would seem to me that the American Medical Association should appoint a committee to study this problem and adopt a simple, standard nomenclature. Then this subject could be discussed more simply and understandingly. A similar situation existed in the nomenclature of thyroid diseases until the American Goiter Association adopted a standard classification for these diseases and the profession has been greatly aided by that simplification.

The controversy concerning the relationship of so-called chronic cystic mastitis and its associated hyperplasias to cancer and what to do has existed for almost a century, and as yet it is not settled. However, I believe now a majority favors the view advanced by Cheatle and Cutler, that various changes found in the female breasts result from repeated hormone stimulations, that various pathological processes follow in logical succession, and that these changes result in cancer in an uncertain percentage of these patients. I subscribe to these views because they seem to explain the various changes I see in breasts. This discussion is an attempt to justify these views.

Physiological Changes in the Breast During Life

It is no wonder that the female breast is so poorly understood because it undergoes a great many changes during its life cycle, especially from puberty to the menopause. Before puberty the female breast resembles the male. It possesses ducts but no acini. At puberty, as the ovaries begin to function, the ducts begin to branch and the smallest branches expand into acini. With the establishment of menstruation the breast undergoes cyclic changes as a result of ovarian stimulation. When fertilization takes place and the corpus luteum persists the increase in progesterone produces remarkable changes in the breast. The gland becomes the seat of extreme epithelial hyperplasia with acini enlarging and new acini forming. There is unbounded epithelial activity, although orderly in character as contrasted with malignancy. When the placenta is discharged the inhibitory agent in the placenta is removed and the proliferative stage gives way to the secretory or state of lactation. When lactation ceases the breast enters into a state of involution but never completely returns to its former state. Thus the breast is continually un-

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dergoing changes until the menopause as a result of hormone stimulation.

In order to understand fully the great influence of hormones on the development of the breast one need only observe the abnormal developments of the breast before puberty in the case of certain lesions of the adrenal cortex, and in association with the granulosa-cell tumors and teratomas of the ovary. Likewise, when estrogen has been given therapeutically in this treatment of gonorrhea vaginitis the breasts develop abnormally. It seems logical that a gland which is so susceptible to normal changes in body hormones would likewise develop abnormal changes when those hormones are abnormal, or somewhat out of balance, and such seems to be the case. Pathological changes in the breast follow a more or less regular pattern.

During the first decade of menstrual life the common pathological changes are the fibroadenomata. Other terms may be applied to these tumors and they can be classified into groups by the pathological picture, but from a clinical standpoint they can be classified together as fibroadenomata. It generally is recognized that they are the result of overstimulation of the breast by estrogen. They may be multiple, and may be small or very large. Others may form after one has been removed. They may develop at any time up to the menopause. They are nodular, benign tumors and in general the existence of a fibroadenoma does not suggest changes elsewhere in the breast which might be malignant or the forerunner of malignancy. However, the tumor in later years may become malignant and when it does the resulting malignancy is usually a sarcoma. Carcinomatous changes are thought to be rare, but Miller and Harrington have reported fifteen cases of carcinoma that developed in previously existing fibroadenomata, and Ewing mentions it as a rare possibility. A fibroadenoma should be removed because:

(1) To establish the diagnosis—the tumor may be malignant.

(2) It tends to get larger and will destroy more breast tissue.

(3) A certain number of these tumors do become malignant.

During the second decade of menstrual life more complicated changes develop in the breast and pathological conditions occur frequently. The term "chronic cystic mastitis" is probably the most common name applied to these changes. However, almost every writer begins the discussion of this subject with the statement that this terminology is a misnomer because mastitis implies inflammation, which the condition is not. Then they proceed to create their own terminology. In 1917 Deaver and McFarland, in an exhaustive treatise on this subject, gave twenty-three names for conditions that could be classified in this group. More recently Lewis and Gescheckter have added adneosis and cystic disease, Cheatle and Cutler have contributed mazoplasia and cystiferous desquamative epithelial hyperplasia, and Boyd has advocated the classification suggested by R. P. Smith, of lobular hyperplasia, which may be cystic or noncystic, and generalized or localized. I believe the last is the best classification yet suggested.

There seems to be more or less general agreement between pathologists and clinicians that the large number of cases of breast changes that the physicians see, between the ages of twenty-five to thirty-five or forty, which are sometimes loosely called chronic cystic mastitis, can be divided into two groups. One condition is physiological and the other pathological. It seems, too, that these conditions are more prevalent now because of the excessive and indiscriminate amount of hormones that many of the women in this age group are receiving.

Non-cystic Hyperplasia—Mazoplasia, etc.

The first is called mazoplasia by Cheatle, chronic mastitis by Taylor, and now cystic hyperplasia by Boyd. This is a more or less normal physiological hypertrophy of the breasts, which causes many women of this age to complain of pain in their breasts, particularly just before and at menstrual time. These breasts become enlarged, tender and congested. In non-fatty breasts, there is a fine nodularity present but no cysts. This condition exists in many women's breasts and is the most common entity for which the patients consult their physicians, in my experience. It is not pathological and not the forerunner of cancer. Many of these breasts can be improved by simple support and assurance of the patient that the condition is not pathological. Often there is an associated pelvic pathology that should be treated. Estrogen does not improve the condition but aggravates it. Anterior pituitary and progesterone have been recommended as treatment, but beneficial results not always have been observed. These symptoms disappear at the menopause.

Cystic Hyperplasia, Cystic Disease, etc.

The second condition found in this age group is pathological and has been given many names, among which are cystic hyperplasia (Boyd), cystiferous desquamative epithelial hyperplasia (Cheatle), and cystic disease (Gescheckter). These patients may have complaints similar to the above group, but in addition they have localized cysts. It is often difficult to differentiate them from the non-cystic hyperplasia group, by examination. The macroscopic picture is cyst formation and the microscopic picture is epithelial hyperplasia. Due to excessive hormone stimulation there is overactivity of the epithelium, in which it develops

layers, with a shedding of the superficial cells, and forms cysts. Not all of these cysts have a high degree of hyperplasia. Many times the large cysts that can be palpated well and are excised are in a stage of regression and show a thin epithelial lining. Some argue that these are not premalignant and treat them by aspiration. They argue that if the fluid is not bloody there is no danger of malignancy. However, I subscribe to the view held by most breast surgeons, that these tumors should be excised rather widely and that this segment of the breast should then be examined microscopically. I have been impressed with the frequency with which our pathologists have found marked hyperplasia in the surrounding tissue and have advised removal of the breast by simple amputation in such cases.

I do not know how frequently such breasts become malignant, but I do subscribe to the view that these conditions are the chief forerunners of malignancy. Almost all observers agree that these breasts do develop cancer more frequently than the normal expectancy for women in this age group. Just how much more frequently it does develop varies with various observers from about three to twenty times the normal expectancy. Many factors must be taken into consideration before deciding to remove such a breast. The chief factor is the degree of hyperplasia, and the view of the pathologist concerning the danger of malignancy. Another factor is the attitude of the patient. If she is extremely desirous of keeping her breasts, and losing them may be a great shock to her mentally, I believe she has the right to risk the hazard of cancer even though the pathologist believes otherwise. However, if the breasts are not of great concern to the patient, and she is willing to follow the best medical advice, I believe that such breasts should be removed more frequently than has been the accepted practice.

I base that opinion upon the advice of pathologists in Indianapolis with whom I have discussed this problem and upon some very unfortunate experiences that I have had in dealing with three such patients during the last two years. These three cases are almost identical and I shall relate one to illustrate the problem.

A married woman, thirty-two years of age, was referred to me in March, 1945, with a small carcinoma in the left breast, a few axillary metastatic glands, and one palpable gland above the left clavicle. She had had only one pregnancy, four years previously, which was terminated because of extreme toxemia. She stated that in 1943 she had consulted a physician regularly concerning lumps in her right breast. In 1944 she had seen another physician in another city, each month, concerning similar small knots in both breasts. She saw him in January, 1945, but missed in February. When he saw her in March he was horrified to find a cancer with definite metastasis already present. She was immediately submitted to radical resection of the breast and all palpable glands and was given extensive deep x-ray therapy. Later, another supraclavicular metastatic gland appeared and the glands of the left side of the neck were resected, followed by surgical castration. To date she shows no recurrence but I doubt that she is permanently cured. Of the other two cases, one is already dead.

Here was a woman who had sought and secured excellent medical advice. She had cystic hyperplasia of her breasts and her physician had diligently watched for changes that could be interpreted as indications for surgery. When they appeared the fate of the patient was probably already sealed. I do not wish to advise unnecessary surgery in any case, but it would seem to me that if we are to make any progress in lowering the death rate from cancer of the breast we must sacrifice more of these breasts in which the pathologists find this picture of marked epithelial hyperplasia with cyst formation. Unfortunately, glandular therapy does not seem to stay the progress of this condition when once it has begun. It is probable that surgical or x-ray castration may delay or impede its progress, but the ovaries are more vital to the patient than the breasts, since they elaborate harmones, which the breasts do not.

Intraductal Papillomata—Bleeding from the Nipple

Following the condition of cystic hyperplasia, and closely related to it, a condition develops which is spoken of as neoplasia by Cheatle, and adneosis by Geschekter. This is characterized by the formation of small, budding growths in the ducts, called intraductal papillomata. They are seldom found singly in a breast, but usually occur in varying frequency in one or two or even more ducts. As they increase in size they may take on the characteristics of an adenoma and may be called papillary adenoma, papilliary cystadenoma, etc. Quite frequently these tumors become malignant. The chief symptom of this condition is bleeding from the nipple, which may be intermittent, or more or less continuous.

What should be done with these breasts which bleed from the nipple? Recently two articles, written separately by Hesser and Wakely, deplored the unnecessary removal of these breasts and advised conservative treatment. Each quotes from Gescheckter, and the experience of Bloodgood, and advises removal of palpable tumors, and when no tumor is palpated, the removal of the duct from which the bleeding seems to come. They state that if no cancer is found in these biopsies there is no more danger of cancer in that breast than the normal expectancy. However, in Gescheckter's review of fifty-seven cases so observed, five or nine per cent later developed cancer, which is approximately twenty times the expectancy for all breasts in this age group.

Adair states that fifty per cent of breasts with

bleeding nipples that he saw were malignant. Judd and Harrington gave a similar percentage and each has considered this an indication for removal of the breast. Greennough and Simmons found that fifteen per cent of their cases were associated with malignancy. In discussing this subject with several pathologists in Indianapolis, their estimations of cancer that they found in such breasts varied from twelve and one-half to forty per cent, although they did not attempt an accurate statistical study. In my own experience, with fourteen cases with bleeding nipples in which no palpable tumor was present, small early cancers were reported in two cases. I subscribe to the view that bleeding from the nipple in the absence of trauma is an indication for surgical removal of that breast. If a cancer is found one must then decide by the size and character of the neoplasm whether simple removal is sufficient or whether radical resection should be carried out.

Another problem has arisen concerning the treatment of cancer of the breast since hormonal stimulation has been shown to play such an important part in the development of cancer. What should be done about castration when breast cancer occurs in women before the menopause? This was advised many years ago and then discontinued. It is being advocated again by many as a result of the glowing reports of the effects of castration of men with prostatic cancer.

Horsley has reviewed the literature concerning the experimental evidence of the effects of castration and large doses of estrogen on mice and rats in regard to breast cancer. This summary is convincing evidence of the great influence of estrogen on the development and growth of breast cancer in these animals. He advises surgical castration of all pre-menopausal patients with breast cancer except mucoid cancer. He presents a report of a group of patients so treated to show a definite reduction in the mortality and morbidity of the group compared to his previous experience. I have had only a limited experience with this procedure, but my conclusions, based upon the literature and discussions with radiologists and surgeons interested in this field, is that the prevailing opinion at the present time is that destruction of ovarian activity should be considered in every case of cancer of the breast in menstruating women. Whether it should be done or not, either by x-ray, surgery, or testosterone, will depend on many factors, including the wishes of the patient in each individual case. There seems to be no doubt, both clinically and theoretically, that it has been of some value in controlling metastasis, in prolonging life, and in saving some lives.

There are several other observations which seem to indicate that abnormal hormone stimulation results in breast changes and breast cancer.

(1) It is well recognized that abnormal breast changes and breast cancer are more common in spinsters and childless women.

(2) Cystic disease and other breast changes are usually bilateral.

(3) Foote and Stewart conclude that women who have had one breast amputation for cancer have ten times greater chance of having cancer in the other breast. They estimate that five per cent of cancers of the breast are bilateral.

(4) Cancers of the breast grow very rapidly in pregnant women.

Summary

While there is still considerable confusion and differences of opinion concerning the interpretation of breast changes, there is abundant evidence that breast changes and breast cancer are mainly the result of the influence of hormones elaborated in the ovary.

What to do about many of these changes will depend on many factors and the judgment of individual physicians. However, if we recognize the fact that certain breast changes are physiological, while others are pathological, and may progress through stages to malignancy in some cases, I believe we will advise the patient more intelligently about what should be done.

It is not my intention to advise needless or unnecessary surgery. Yet, too often, I have been confronted with cancers of the breast that cannot be cured with any known type of treatment, especially in comparatively young women. Then they would submit to any type of treatment if only they could live, but often their doom is sealed at the earliest sign of malignancy. It seems that we must recognize these conditions earlier, before a well established malignancy is present, if many patients are to be saved from death due to cancer of the breast.

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LEUKOPLAKIA AND CARCINOMA OF THE VULVA

David A. Bickel, M.D.

South Bend

THE direct association of leukoplakia and carcinoma of the vulva has become an accepted clinical observation. For many years the condition now generally described by the term "leukoplakia" has been confused by an assortment of names. It was first referred to by Breisky in 1885 as "kraurosis vulvae." Kraurosis vulvae literally means shrinking of the vulva and describes the late and atrophic stages of the disease. Later in the confusion of nomenclature the condition has been described as leukoplakic vulvitis, leukokraurosis, and chronic atrophic dermatitis of the vulva. The latter name, proposed by Adair and Davis, [1,2] is accurately descriptive.

In 1929, Graves and Smith,[3] and later, Brewer[4] and others expressed the opinion that various names given the disease described different stages of the same pathological process. Adair and Davis have presented an extensive study of pathological changes associated with the condition. They have shown by histological and clinical study that what were considered distinct disease entities were really progressive stages of the same process, and that these changes may progress from an inflammatory reaction to malignancy.

This study presents a small group of cases, seventeen in number, of leukoplakia of the vulva. The discussion of malignancy included in this report is limited to the cases which are associated with leukoplakia and does not include other carcinomas of the vulva or vagina. Carcinoma developed in five of the seventeen cases reported in this study. The accompanying table gives the age of the patient when first seen, the duration of symptoms, the frequency of malignant change, previous treatment, treatment given, and results to date. Many of these patients have not been observed for a long enough period to determine if they are permanently cured.

Etiology and Pathology

Leukoplakia of the vulva usually occurs at the time of, or after the menopause, and rarely occurs in younger women. In the cases reported the ages varied from thirty-three to seventy-one years, an average age of fifty-one years. Because of its appearance at the time of decreasing ovarian function, its etiology is very probably on an endocrine basis. Avitaminosis has also been suggested as an etiological factor. It may occur in women who are menstruating regularly and is not frequently observed in women who have had premature menopause, either by surgery or radiation. The fact that estrogen therapy has been used without success in the treatment of the condition would lead to the conclusion that some endocrine factor other than estrogen deficiency is involved. As the result of trauma due to scratching, small blebs and abrasions appear on the skin and infection supervenes. Inflammatory changes appear to be a secondary factor in its causation. In the early stages of the disease the entire vulva may become involved in an inflammatory process. At this stage some relief is afforded by soothing lotions and ointments. When the inflammatory process subsides the skin becomes thickened and of a grayish color. The folds of the skin become indistinct and the labia minora may disappear entirely. In this hypertrophic stage there is marked thickening of the keratin layer of the skin with edema in the underlying tissue. The process may be limited to a small area or may involve the entire vulva, the perineum, and the skin surrounding the anus. Even after all the involved skin has been removed, recurrence may take place in surrounding areas.

The atrophic stage is what was originally termed kraurosis, or shrinking of the vulva. The skin loses its elasticity, becomes thin and glistening and parchment-like. With the shrinkage and loss of elasticity of the skin there is marked constriction of the vulvar orifice, making coitus painful and often impossible. From time to time abrasions and fissures occur in the stiff and inelastic skin. These breaks in the skin in time become ulcerated and secondarily infected. The pathological changes involved in the various stages of the process may extend over a period of many years. It is in these ulcerated areas that an epithelioma may have its origin. While the process may be advanced in one area, other areas may exhibit the early stages of the disease. The development of an epithelioma may cause the patient to have severe localized pain or may cause no discomfort which was not previously experienced. Fortunately, after malignancy develops the neoplasm may remain localized for a long time, affording opportunity for diagnosis and curative treatment. In five of the seventeen cases observed carcinoma was present when the patient was first seen. Two early cases of carcinoma had observed symptoms for less than one year, but the two advanced cases had suffered serious discomfort for three and five years before the diagnosis of malignancy was made.

[1] Adair, F. L.; Davis, M. E.: Chronic Atrophic Dermatitis of the Vulva, *Surg., Gyn. and Obst.*, 61:433, Oct. 1935.

[2] Adair, F. L.; Davis, M. E.; Schuitema, D. M.; Atrophy of the Vulva, *J.A.M.A.*, 114:296, Jan. 27, 1940.

[3] Graves, W. P.; Smith, G.; Van, S.: Kraurosis Vulvae, *J.A.M.A.*, 92:1244, 1929.

[4] Brewer, J.: Kraurosis and Leukoplakia of the Vulva, *Illinois M. J.*, 77:26, Jan., 1940.

Age	Duration of Symptoms	Development of Malignancy	Previous Treatment	Treatment Given	Outcome of Case
65	3 years	Advanced	X-ray	Simple vulvectomy	Dead
64	3 years	None	Local medication	Simple vulvectomy	Cured
41	2 years	None	None	Simple vulvectomy	Recurrence around anus
40	2 years	None	Estrogen	Simple vulvectomy	Cured
57	5 years	Unilateral	X-ray	Radical vulvectomy	No carcinoma in glands
55	6 months	Early	None	Simple vulvectomy	No recurrence for 1 year
43	4 years	None	X-ray Alcohol injection	Simple vulvectomy	Complete relief of symptoms
36	1 year	Of clitoris	None	Radical vulvectomy	Well after 12 years
71	5 years	Advanced	X-ray	Simple vulvectomy	Dead
63	4 years	None	X-ray	Simple vulvectomy	Complete relief
35	5 years	None	Estrogen	Refused	No improvement
42	3 years	None	X-ray Local medication	Refused	No improvement
53	5 years	None	Estrogen Local medication	Simple vulvectomy	Complete relief
33	2 years	None	Estrogen	None	No change in lesion
36	1 year	None	Estrogen	Wide resection of lesion	Free from discomfort No further involvement to date
46	3 years	None	Local medication	Simple vulvectomy	Complete relief
50	2 years	None	Local medication	Simple vulvectomy	Complete relief

Symptoms

The symptoms of leukoplakia are almost uniformly pruritus, burning, and later dyspareunia. The itching and burning may be mild and persist for many years, but usually becomes severe and intolerable and is not relieved by the usual antipruritic lotions and ointments. In some patients the degree of discomfort has been so marked that they have stated they were more comfortable during the postoperative period than they had been for months. Micturition usually causes pain and burning as may occur with a urethral caruncle or mycotic vulvitis in diabetes.

Treatment

In the seventeen cases observed, fifteen had applied many kinds of local medication, five had received estrogen therapy, and five had been treated by x-ray. Three of the cases where carcinoma had developed were previously treated by x-ray. Following its use there was no relief of symptoms and no retardation of the growth. But on the contrary, the itching and burning were increased as the result of radiodermatitis. In nine cases of leukoplakia, one with early associated carcinoma, where simple vulvectomy was done, there was complete relief of symptoms and no recurrence of malignancy. Simple vulvectomy was done for palliation in two cases of advanced malignancy. Both patients died of metastatic carcinoma in less than two years. Inguinal gland resection, the Bassett operation, was performed with vulvectomy in two cases of moderately advanced malignancy. These patients are alive, for two and ten years respectively. In only one case, that of a woman thirty-six years of age, local excision of skin less than the entire vulva was performed. In such a case, frequent observation is important, and if there is any recurrence of leukoplakia vulvectomy should promptly be performed. Even when complete vulvectomy is done these patients should be examined at regular intervals for years, and if remaining skin becomes involved it should be removed.

The inescapable fact that one-half of all cases of leukoplakia of the vulva will develop carcinoma, and the poor results with all palliative treatment leaves surgery as the only effective therapy. Taussig[5] in one hundred four cases of carcinoma of the vulva found that seventy-two were preceded by leukoplakia. Similar findings have recently been reported by Watson and Gusberg.[6] While leukoplakia of the vulva is the most important precancerous lesion of the body its proper treatment offers our best opportunity in prevention of carcinoma. The serious discomfort accompanying the early stages of the disease affords a singular opportunity for early treatment which is not always possible in early malignancy of other parts of the body.

When carcinoma has developed in the course of leukoplakic disease surgery more extensive than simple vulvectomy is imperative in all but early cases. In a series of one hundred fifty-five cases, Taussig has obtained a five-year cure in 58.5 per cent by vulvectomy and resection of the inguinal and femoral glands. The radical operation was performed by him in sixty-eight cases. The operation may be done in one or two stages, depending on the age and general condition of the patient.

[5] Taussig, F. J.: Cancer of the Vulva: Analysis of 155 cases (1911 to 1940), *Am. J. Obst. and Gyn.*, **40**:764, Nov., 1940.

[6] Watson, B. P.; Gusberg, S. B.: Prevention and Treatment of Carcinoma of the Vulva, *Am. J. Obst. and Gyn.*, **52**:179, Aug., 1946.

Summary and Conclusions

1. Seventeen cases of leukoplakia of the vulva, five of which developed carcinoma, are reported. This report reaffirms more extensive studies of others that surgical treatment of leukoplakia is definitely important in the prevention of carcinoma.

2. Radiation therapy has not proved effective for the cure of leukoplakia or the prevention or cure of carcinoma of the vulva.

3. When carcinoma of the vulva is present the only hope of cure is vulvectomy and inguinofemoral gland resection.

THE PSYCHIATRIC TREND IN MEDICINE*

E. VERNON HAHN, M.D.

President of the Indianapolis Medical Society for 1946

INDIANAPOLIS

It does not occur to us ordinarily that we could save ourselves considerable sense of shock and bewilderment at the course of affairs by pausing for historical reflection.

When astonished at the course of events we should ask ourselves, "Could it be that humanity has passed this way before?" making allowance for superficial differences in the external forms which can be assumed by repetitious trends.

Perhaps this principle of historic repetition can be invoked to explain, in part, the current devouring interest in psychiatry. We are again in a postwar period.

Looking backward, let us note that it was in the closing years of the French Revolution that Pinel fired the enthusiasm of Europe for psychiatry by throwing open the madhouse dungeons and unshackling the lunatics. Our own Civil War had scarcely ended when George Beard popularized the concept of neurasthenia, starting a wave of interest in neuropsychiatry which led to the fine work of S. Weir Mitchell and others. Again in Europe, the close of the War of 1870 marked the turning of the great Charcot from the problems of organic neuropathology to those of hysteria. Again, after World War I came a great wave of enthusiasm for psychiatry, and the mental hygiene movement achieved its greatest development. Why, then, should we expect anything else today than a great expansion of interest in all things psychiatric?

Why should it always turn out so? The answer might well require infinite insight but one may advance the surmise that the emotional impact of war, with all its deprivations, perils, and griefs, inclines us toward panicky discontent with the imperfections of the world we live in. Doubtless humanity proceeds by correct intuition when it directs its attention at such times to the most baffling and the most challenging of all imperfections—the imperfections of the human spirit and the human mind.

But whether or not we understand why, it seems we are to live through a period of intense psyciatric activity. We had better allow more room in our thinking for psychiatric concepts than we have in the past or relegate ourselves separately and individually to unhappy dodoism. As a group the medical profession cannot dare a futile attempt to stem this tide of psychiatry. Nor can it fail in its responsibility to lend its strength and guidance to a social movement which, without such guidance, might wreck itself and leave society worse off than it was before.

I promise you it is no chimera I am showing you. Lay persons without number, that is, lay as far as medicine is concerned, have taken hold of this cause for bettering and curing all those who are mentally halt, lame, or blind. Unfortunately, they do not talk much of bettering but almost exclusively of curing. Since their minds are medically undisciplined they undervalue palliation. Without saying so they want a panacea. Unquestionably they will hurt themselves and society, also, unless they are led toward more modest expectations.

Verily, humanity seems to have wandered inadvertently into a deceptive maze of perfectionistic idealism. These enthusiasts speak confidently of preventing mental illness, juvenile delinquency, and criminality by the agency of educational appeals and various psychiatric services presently to be made widely available. If only they would speak more softly of ameliorating conditions a little by many decades of steadfast effort, we doctors might view the present tide with less alarm. Is it not the duty of us doctors to remind our lay psychiatric friends of such irrevocable conditions as congenital defects, hydrocephalus, encephalitis, and traumatic encephalopathy? Must we not teach them that not everything bad is reversible or preventable?

It seems to me that the most potent apparent stimulus of all this fever for psychiatric action was the publication of misunderstood statistics developed by the Selective Service in the recent war. We were told that some million registrants were disqualified for military service for neuropsychiatric reasons. This fact was held up for

* Presidential Address presented before the Indianapolis Medical Society, at Indianapolis, on January 4, 1947.

our shame. Congress reacted by setting up a National Council for Psychiatric Service, putting at its disposal for an indefinite period of time practically unlimited resources for the setting up of mental hospitals and psychiatric clinics. With wisdom, most fortunate wisdom, those who drafted this legislation provided responsible and expert control of the energy soon to be visited upon us. The Council understands that there are not now, and probably never will be, enough psychiatrists to accomplish the idealistic aims of this legislation. The first job will be that of training more psychiatrists so that the law may be given respectable implementation to the end that the level of mental health in our society may be improved a little.

But psychiatrists can never carry out this assignment alone. It takes too long to train a well-qualified psychiatrist, who first must be a physician, then a neurologist, and finally, a psychiatrist. The assistance of the ancillary professions of clinical psychology, psychometry, and psychiatric social service will have to be thankfully accepted by the psychiatrists staffing these clinics. The medical profession, however, must see to it that these professional services remain ancillary, as otherwise the whole psychiatric effort would certainly lose its scientific rooting in the fruitful soil of biology.

Not only with respect to the socialized psychiatric movement I have described all too briefly have we, in our time, been challenged by psychiatric thinking. In our private practice, in our medical teaching, in whatever department of medicine we follow we cannot cut, scrape, squeeze, manipulate, or administer clyses, physics, or even hormones without due consideration of the psychiatric status of those who come to us for help. Those who try to need not be surprised to find themselves in botles on museum shelves. Modern medicine has become "psychosomatic."

Perhaps you have thought that psychosomatic medicine is just a new specialty invented for "queer ducks" who can no longer take pride in an honestly pounded pill. Perhaps it has been given such a twist by some devotees of a character to hang on to the tail of any new kite. But in its origin, psychosomatic medicine was the inevitable result of the permeation of well demonstrated principles of psychoanalysis into the treatment of those neuroses whose symptoms consist chiefly of physiologic disturbances.

The vast majority of persons with such neuroses take their ailments to general practitioners or to medical specialists other than psychiatrists or psychoanalysts. There is good reason for this. The sufferers themselves do not know that the bodily symptoms are psychogenic. Most of them are unwilling, particularly at first, to acknowledge the possibility of emotional causes. Furthermore, why shouldn't they first consult physicians who are trained to recognize morbid physical conditions? These sufferers from neurosis are certainly guided correctly by their intuition when they consult those who should be best able to make a differential diagnosis.

Even when it comes to treatment, the vast majority of these cases of neurosis must continue to be the responsibility of physicians in general practice who must therefore assimilate as best they can a modicum of medical psychology—call it psychiatry or psychoanalysis, if you will. In expanding their thinking to embrace some psychiatric concepts and in modernizing their practice to employ, perhaps covertly, some psychiatric methods, general practitioners may find themselves more adequate than they expected, particularly if they turn consultations to their educational advantage. The worst possible solution of the practitioner's dilemma in the majority of these cases is the conclusion, "I'll unload this neurotic onto some psychiatrist." There simply are not enough psychiatrists, and there never will be. The upshot of that policy, therefore, usually will be that the patient will find another and more willing general practitioner.

The psychiatric challenge of the "organ neuroses" I have just been describing is no smaller than the one involved in the treatment and prevention of the psychoneuroses and personality problems I first discussed; if anything, it is greater. A psychiatric colleague just recently related to me the result of an interrogation of a large group of internists who happened to be taking a course in the treatment of the neuroses at one of the training centers. My friend was the only psychiatrist in the group. The instructor asked what per cent of the case-load of these internists were psychosomatic problems and the answers ranged from 40 per cent to 80 per cent. I thought it was a promising sign of the times that these internists who had an awareness of the problem confronting them were not bent upon becoming specialists in psychosomatic medicine, but were trying to improve their use of a string which was already in their fiddle.

As I said at the outset, it would be a mistake to represent this current wave of interest in psychiatry, two phases of which I have mentioned, as a strictly modern phenomenon. The Greeks, you know, practiced psychologic medicine and the Romans knew how to use rest and baths for the relief of bodily ailments. But the trail was lost in medieval times and had to be rediscovered. The story of that floundering rediscovery is as interesting as any chapter in the annals of the race.

I once interested myself in a quest for the origin of the word "neurosis" in medical literature. At the time I had access to a large medical library and I worked my way back until I found the first medical author to use the word—William Cullen, who wrote his enormous system of medicine in the last part of the eighteenth century. He stated that he intended to group a certain number of disorders under that caption, borrowing and anglicizing the French word "nevrose." Then Cullen proceeded to describe tetanus, diptheritic paralysis, and several other purely organic diseases, along with dis-

orders which are now clearly recognizable as hysteria and organ neuroses. The remarkable fact is that Cullen recognized the relation of the symptoms of these true cases of neuroses to the emotions and life histories of the patients. Lacking a knowledge of bacteria he offered no explanation for his other "neuroses." Truly, Cullen was the first English writer to describe and correctly evaluate phenomena which in the last decade have been given the rubric "psychosomatic disorders." Is there anything new under the sun?

Yes, there are rare new discoveries. What has been called the "pathetic quest for oxygen" resulted in a key discovery which set modern science going. Other absolutely novel discoveries in rather quick succession put modern physical science on its feet. A wealth of new knowledge then overwhelmed medicine with physical agents and material tools, the exploitation of which is not yet complete. It is small wonder that Cullen's psychiatric insight remained ensepulchered in musty tomes on dusty back shelves of libraries. The only psychiatry left living was the mysticism of the spiritualists and hypnotists.

A new epoch began when Charcot turned toward psychology, for Charcot inspired Freud whose own point of departure was neuropathology. And Freud had the genius for completely novel discovery. This new knowledge under the sun provided psychiatry with implements it previously lacked. So it is that now, for the first time, medicine is feeling the full impact of a cult which became scientific and integrated with biology only fifty years ago.

Medicine will not tremble at this impact, nor be pushed over and lie shattered in the dust. If overzealous evangelists of a perfect world shout promises they cannot fulfill while casting subtle obloquy toward us for having less than miraculous power, we need only stand firm in the conviction that our profession has lately served humanity well—at least better than it ever was served before in the world's history. That conviction will teach us to answer firmly when we are charged with dereliction for not having cured the incurable and for not having prevented the inevitable. When the tumult and the shouting have become less raucous we may be able to help those panicky souls who demand more and more psychiatry for others, with—psychiatry! They need to know that their demand for a perfect world is fed from springs of discontent within their own, unsweet selves and from delusions of soul-satisfying omnipotence which would destroy them if they had it.

Neither will medicine prove stubbornly resistive and obdurate in its loyalty to the material world. For that it has been taught by too many humanists who have set a noble example of scientific open-mindedness. That which is valid and useful in psychiatry will be accepted in time and integrated with what we have learned otherwise of the workings of nature. May the impatient ones only learn to take it easy. Sound building requiries maturing of design and time for workmanly construction.

PNEUMONIA FOLLOWING CHEST INJURY PREVENTABLE

Pneumonia, following injury to the chest, can be prevented with large doses of penicillin or sulfadiazine, according to Edward Phillips, M.D., of Oakland, Calif.

Writing in the January 18 issue of *The Journal of the American Medical Association*, Dr. Phillips presents his observations on 73 patients treated at Permanente Foundation Hospital for pneumonia following injury to the chest.

Of these 73 patients, 43 had fractured ribs, one had a fractured shoulder blade and one had a fractured breast bone.

The author cites two investigators who demonstrated by animal experimentation how a blow to the chest, with or without fracture of the ribs, can produce injury to the lungs. The blow stimulates the vagus nerve, which extends from the cranium to the lungs, to contract the bronchial tubes which results in a partial collapse of the lung. This collapse area becomes infected because it lacks areation.

Injections of atropine into the veins, which paralyzes the terminal fibers of the vagus nerve, will prevent or minimize the chances of collapse and infection following injury to the chest, states the author. Large doses of penicillin and sulfadiazine will sterilize the lung area.

Additional facts regarding the 73 patients follow:

In 54 patients (74 per cent) pneumonia developed only on the same side as the injury.

The majority of patients had a mild type of pneumonia.

Over 92 per cent of pneumonia cases occurred within six days of the injury.

Over 50 per cent of the patients recovered within one week.

Three patients died with a resultant mortality rate of 4.1 per cent.

Twenty-six consecutive patients with severe chest and lung injuries who were treated with large doses of either penicillin or sulfadiazine did not contract pneumonia or other complicating infections.

THE JOURNAL
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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

As We Read It

The much-talked-of "Taft Public Health Bill" was introduced in the United States Senate as of February tenth. For some time we have heard comments on what the proposed law might mean and have awaited a copy of the original bill with much interest.

In many ways it differs from the various Wagner-Murray-Dingell proposals; in fact, it is a marked improvement over these former proposals. However, there is much in the new bill that can be criticised.

The first noticeable thing is that all health activities, in so far as the Federal Government is concerned, save those having to do with the armed forces, will come under this proposed plan, subject to the directing heads thereof. Another outstanding thing is that the Director of Hospital and Medical Service shall be a Doctor of Medicine—this of course being as it should be, in the event we are to have new legislation in the matter. It also seems that each state shall have a local director, and measures are provided to settle any disputes between said states and the federal director.

The administrator is charged with making an annual report to the Congress covering all disbursements made by this department, and relating in some detail just what has been accomplished. Another paragraph provides that the administrator, after he has been in office for some six months, is to make suggestions relative to the present commissioned corps of the Public Health Service and stating his recommendation regarding the establishment of a Health and Medical Research Unit in the agency.

Section 712 provides that "any state desiring to take advantage of this title may submit a state plan for carrying out its purposes." This plan, however, must meet certain requirements. First, *a single state agency* must be designated as the sole agency for the administration of the plan and the supervision thereof. The Governor of the state must name a Medical and Hospital Care Advisory Council. This council shall be made up of "non-government organizations or groups," and the various state agencies engaged in health work.

Within five years plans must be worked out to provide medical services for all families whose income is insufficient to pay the usual fees therefor; also, periodical examination of all children in primary and secondary schools. This proposed med-

ical care, at the option of the individual states, may be carried out in the home or in hospitals.

A rather elaborate setup is provided for the distribution of Federal funds to the states which arrange to participate in the full program, details of which cannot be undertaken here at this time.

Dental care, of course, is arranged for under plans similar to that for medical care.

The fund allotments will be based on the population of the state applying for membership in the plan, plus a consideration of the amount of money each of said states has spent in health work in previous years.

A review of the proposed legislation brings out two or more important considerations; one is that the original bill provided that either a doctor of medicine with at least eight years experience in the United States Public Health Service, or one licensed to practice in one or more states, and having at least five years experience, with three years or more in medical research, should be named as administrator. The revamped bill provides, as already stated, that this official must be "a doctor of medicine licensed to practice in one or more of the states and who is outstanding in the field of medicine."

We are advised that a change will be made in the medical research provisions in the bill whereby ten million dollars will be appropriated for a cancer program.

The entire measure affords a bit of interesting reading on medical economics and, while in no sense as radical as other measures hitherto proposed, will stand a lot of close scrutiny.

We also are advised that, even though defeat has been his lot in former proposals, Senator Murray, of Montana, will again take a fling at it, having in preparation a bill to take the place of the much-discussed Wagner-Murray-Dingell proposal.

This Matter of Deafness

For many years the medical profession has been fully aware that deafness, in some degree, is mightily prevalent and that until rather recently not much has been done about it. The April number of *The American Magazine* carries an article, "Can You Hear?" that is about as factual a thing as we recently have seen in a lay magazine.

It avers that some 15,000,000 Americans have some sort of defective hearing and that, unless remedial steps are taken, many of these will become more affected. The author comments on the fact that for many years our otologists have endeavored to interest affected persons in proper treatment, but with little success, until in very recent years.

We will not go into the various causes that bring about hearing troubles, rather we wish to comment on some of the remedies used, principally the hearing devices. The magazine article mentions many of these, not by name, and the author indicates that he has made a real study of them, talking to the manufacturers as well as to the users. He states that some 400,000 persons are now using some form of these devices and naively states that some 10,000,000 more need them.

Several years ago a survey was made of some 2,000 purchasers of these instruments and it was found that about one-fourth of them were using the devices.

We recommend that every physician read the article in *The American Magazine* for April; it contains a lot of wholesome suggestions which, if followed, will materially assist in the prevention of deafness. Too many of us are prone to dismiss such matters when brought to our attention. We neglect to suggest that children should have hearing tests at regular intervals; that these tests should be made after recovery from all acute illnesses and even after recovery from "the common cold."

There is another factor in the problem that, to us, is very important. With a "ten million market" to work on there is no wonder why hearing devices are being advertised so extensively as at the present time. And, sad to say, some of this advertising is at least misleading—it buoys the hope of the afflicted—he seems to believe that at last he is to hear as well as the normal person.

It is our opinion that before trying out any of these devices one should consult an otologist, who probably can offer sound advice as to whether a hearing aid will be of service and, if so, the best type for that particular patient. We have no quarrel with the manufacturers of these devices, rather do we suggest a little more "slowing down" of extravagant claims.

Again we say, read this article—*The American Magazine*, for April, 1947.

On Making Appointments

In the February ninth issue of *The Indianapolis Star*, Lowell Nussbaum, in his daily column, "The Things I Hear," has somewhat to say on the subject of appointments with the doctor. He remarked that last December he had asked for an appointment with an Indianapolis physician and was told by the secretary that it would be some weeks before this could be made—that she would advise him later on as to the date set.

February eighth the young lady called Nussbaum and asked if he could come over that afternoon. Lowell replied that he had gone elsewhere for treatment, hence the "appointment" could be marked off.

One of his readers was quite interested in this little skit and wrote us a letter about it—anonymously, of course. We have checked the letter from every possible angle and it is our conclusion that it was written from some doctor's office, *by his secretary!* It is merely signed "A Patient Patient."

She first discusses "this new plan of making appointments," evidently referring to the fact that

in these modern days appointments are quite common in medical offices. Says that even though one has an appointment the doctor is frequently late in arriving, thus creating delay number one.

Another thing she complains of is, "the patients are not disposed of with any greater rapidity by this new method." She says, "But my greatest complaint is that all too often we are informed that the doctor is so busy that an appointment cannot be made for some weeks." She says the reason the patient wants to go to the doctor is because he is ill and illness cannot await the convenience of a future appointment.

Later on in the letter the writer suggests that at one of our annual sessions we have a symposium on "Office Appointments," which is not at all a bad idea; in fact, we often have felt that in our annual sessions we do not get down to "common principles" frequently enough. An hour or two devoted to business details would be of much interest and profit to all.

"Then," she says, "have another symposium and discuss the courtesy (and the lack of it) of those who answer the telephone and make the appointments for the doctors."

Well, the young lady has something there, we believe; in fact, she says a lot of things that are well founded on fact. The old days when one just walked into a doctor's office, sat down, and looked over some ancient literature for awhile, saw the doctor, took his pills and little bottle and walked out, are gone; indeed they are GONE, and probably for good. In this hurry and hustle age, when the progressive man wants to get everything possible out of every minute of his office hours, there just has to be some "system." In an experience covering forty-five years we have learned a lot about that; we have found that by scheduling this and that we get more done and do it more expeditiously.

There are, of course, many instances in which delayed appointments are necessary; men who have a highly specialized field and whose examinations require a lot of time, must work according to schedule. Not long ago we wrote an otologist in a neighboring city, asking for an appointment for a member of our family; after about ten days the appointment card came, naming a date some two weeks later. Incidentally there was a little notation on the bottom of the card that might be of interest to a lot of us. It was to the effect that in case the appointment could not be kept twenty-four hours' notice must be given, else there would be a charge made for the time lost.

This examination revealed the need for a hearing aid, and though these had been tried they had not proved satisfactory. So the specialist advised going to another man, connected with one of our great universities—a physical laboratory, if you please. That meant asking for another appointment, which could not be had for some three weeks. However, all these visits were productive and the new hearing device promises very good results.

Then there is the matter of telephone courtesy; there are too many reasons for complaint in this regard. Some secretaries are friendly, some are curt, and some are just plain blunt, when answering the phone calls. The reason most people call the doctor is because they feel they need his help and advice; they at least think there is something wrong with them and when one feels that way he does not care for curt answers—he prefers the "sympathetic" tone! We have, on occasion, called the office of a physician and in no time had our dander up because of the manner in which our conversation was being accepted—we even have snapped back a time or two, hung up the receiver, and for a long time did not try to call that doctor again.

Well, Lowell, you've got something on us, and the young lady, too, has said some things that make us think a bit. We'll see just how soon we have one of these symposiums and when we do we will send you copies of THE JOURNAL in which they are published.

Editorial Notes

All indications point to a record registration at the Centennial Anniversary of the American Medical Association, this next June. The meeting is to be held in Atlantic City, one of the few places in the country able to house such a mammoth gathering. If you are planning to go and have not yet made your reservations, better get in touch with Ray Smith, at headquarters, who will advise you just where to make application for quarters. At the same time, better make your reservations for the French Lick meeting, in October. We expect a record attendance for this event and early registration is most important.

Notwithstanding the calendar and the fact that we have been having a lot of winter, with plenty of snow, we went down in the basement the other day, got out a "flat" and planted some Bibb lettuce. Early in April, if we can break the ground, we plan to set this out in the open, thus getting an early supply of this delightful variety of "green stuff." Bibb, you know, will not stand for hot weather and has to be matured before the really warm days come along. As for tomatoes, peppers, and that sort of plants, we are willing to let the greenhouses do the early work for us. To those interested in having a few tomatoes in the back yard, we offer a bit of advice—*do not plant tomatoes near a walnut tree*—they just will not thrive there. We had tried it for years and it would not work out well. This year an article in our favorite horticulture magazine tells why—there is a sap or exudate from the roots of the walnut tree that definitely is unfriendly to tomatoes. Beans, beets, and onions seem not to mind this, but the tomato will not thrive in the same area.

T. A. Hendricks, secretary of the A.M.A. Council on Medical Service, in a news letter under date of February twenty-fourth, states that prepayment medical care plans are progressing at a very satisfactory rate and that the 1947 program will show a continued increase in the success of the various plans throughout the country. At the present time more than five million Americans are covered by such plans, eighty-four of which are in operation at the present time. Practically every state has such a plan, though a few are not yet in full operation. All of which reminds us that at least since 1932, when we first heard such a plan mentioned in any official medical meeting, the matter has been under rather general discussion, and only comparatively recently has there been any concerted effort to bring such things about. In this connection we cannot refrain from commenting on the fact that not too long ago the parent organization, the American Medical Association—at least its officials—were definitely not sold on such plans; today that same organization has in full operation a special committee covering this service!

Santa Claus has moved! Yes, Sir, just packed up and moved, bag and baggage—but not too far away, just a mile. This little hamlet, located down in Spencer County, dates back to 1855. The year before a number of the residents of that community petitioned for a post office, the hamlet then being known as Santa Fe. But, because there already was a Santa Fe, Indiana, the Post Office Department ruled that duplicate names could not be used. About a year later, at a Christmas season meeting in a nearby church, the name Santa Claus was suggested and adopted. Our first visit to this community was made several years ago and, like most other visitors, we bought post cards and had them stamped "Santa Claus, Indiana." In later years we again visited the place and found many changes. A Santa Claus "park" had been essayed, with a huge stone Santa in the center. The little country store in which the postoffice was then located had an annex, in which gifts of all sorts were sold. Now comes the announcement that a new building had been erected, one mile from the original site and the commercial spirit holds full sway. Older residents of the community have remonstrated against the change, even to the extent of seeking the support of Senator Capehart, but it now seems that Santa Claus, Indiana, has definitely changed locations. For many years past thousands of United States citizens have had their Christmas cards mailed from Santa Claus, for sentimental reasons. Extra clerical help has been sent in each of the holiday seasons and it is reported that in 1946 almost *five million* pieces of mail were handled there. We are glad to learn that, even though the old post office has been moved a bit, it still will be Santa Claus, Indiana; thus affording coming generations of youngsters, as well as some oldsters, to notice the quaint postmark.

The Research Council for Economic Security recently sent out a pamphlet on "Our National Health Problem," the front page of which is a map showing health conditions in the various states, the ratings being good, fair, poor and bad. Indiana comes under the "fair" classification. This is indeed most encouraging for not too many years ago Indiana had a rather poor rating in matters of health, but with the marked activities of our State Board of Health, plus the assistance rendered in most of our counties, this rating gradually has improved. It is interesting to note that practically all of the Southern States—all save Texas and Florida—have a "bad rating," while the West Coast States are all rated as "good." This rating also applies to Illinois, Michigan, Ohio and New York. It is an interesting observation that these states with such a high rating have a high per capita expenditure for health affairs.

Rollis Weesner, executive secretary of the Lake County Medical Society, in the monthly *Bulletin* issued by the Medical Business Office of that organization, takes occasion to comment on the subject of "Taxes." Probably had read what THE JOURNAL had to say on this matter, a few months ago, and thought it proper to make some additions. We append his comment:

A practical joker in one of the European countries, so the story goes, recently was ridiculing the man and various sources of taxes. His comment was that everything was taxed except obesity. According to reports (the editor refuses to vouch for the authenticity of these) the government officials are taking the suggestion seriously and have proposed to inaugurate legislation imposing such a tax.

Maybe there is an idea for another source of taxes for our lawmakers. Why not a tax for all persons measuring in excess of a certain girth—the basic measurement to be sufficiently low so as to include at least ninety per cent of our present population. The idea opens up a train of thought from which our tax-makers could obtain sufficient new sources that would entirely solve the tax problem in America.

Along with the above suggestion why not a tax on the many patent cures advertised so blatantly over the radio and in our periodicals. As someone so aptly stated recently, never has so much been written on medicine by so many who know so little. Taxes derived from this source (and my guess is they would approximate New Deal figures) could be earmarked for medical services for the indigent.

An especially high tax should be imposed on those who give their time to idle boasting and idle gossip. A still heavier tax could be levied against those who mix liquor and gasoline, or in fact any who overstep the bounds of temperance should pay the penalty. Since Americans dislike paying taxes it might turn the country into a more moderate nation. Still another source could be taxes for those who read a newspaper over your shoulder, or the neighbors who borrow your garden tools and then return them in November only to borrow your snow shovel. Penalties against those who call you on the 'phone and then babble "guess who this is" and for those who insist that they "can get it for you wholesale," would assist tremendously in distributing the tax burden—where it belongs.

Yes, it appears that the surface hasn't even been scratched as to sources of taxation.

President's Page

DEMOCRACY vs. STUFFED SHIRTS

Wags a Washington newspaper writer: "Democracy is the hole which lets out the sawdust from the *stuffed shirt!*"

Ever thriving upon the truly fundamental principles of democracy, the great Indiana State Medical Association has no *stuffed shirts.*

The writer of these lines in times past frequently has been good-naturedly ribbed about use of the phrase "the great sovereign state of Indiana," and the chiding has been accepted with equally facile humor. Nevertheless, to all who would read and know history, Indiana is a *great* state. Neither the youngest nor the oldest, it is neither North, nor South, nor East, nor West; geographically somewhat east of the middle, for decades it has been the population center of the United States. Neither Republican nor Democratic, it also is neither leftist nor rightist; it maintains a proper balance. Neither predominantly urban or rural, manufacturing and agriculture are in reasonable ratio. It is just truly an American state, a *great* state. Be not too timid to brag or to laud! Others will accept your own valuation!

By the same tokens, the Indiana State Medical Association is a *great* association. It has no *stuffed shirts.* Why? Because purest democracy prevails from those very highest placed right down the line to individual members of the grassroots county society. The very foundation stone of our great association, your county society is you; the individual you is your county society. Upon your organized activity and effort and sacrifice depends the whole. Yes, this is a ninety-eight-year-old story, but it needs continual repeating lest we forget—and, perhaps, neglect!

The county society knows, or should know, local conditions, professional and lay. It should govern and control all aspects and phases of medical practice, both in and out of hospitals. Upon its shoulders rests the burden of good medical care for all its own people, and it rightly must assume and maintain leadership in every civic and public affair related to such care. Its congressman in Washington and its representative in the state general assembly reside in its community. Are they among your friends? Are they favorably impressed toward organized medicine? If not, wherein lies the fault? Poor medical practice? Poor public relations? Or what? Who fumbled the ball?

Write this down and double-underscore it for all time, past, present, and future; the properly organized county society can practice as it will within its own confines, and a state association of such organized county societies can do the same at the state level. But, have you the *will* to do so? It's either that—or else!

In the county society every member can and should rise to discuss his ideas on medical practice. This is not merely a privilege; it is a duty. If the tenet is good, the society as a whole can decide upon the necessary action or procedure. Perhaps the question should be resolved at the state level; the House of Delegates, the Council, and the Executive Committee always, always, always are accessible in the truly democratic way to each and to all, this for the common good of the many. This is democracy! At work!

At work? How? Let's review history, past and present, just a mere few of many events, the recital of which could fill every page of this issue.

Fifty years ago, in 1897, under the able leadership of Dr. Frank B. Wynn of Indianapolis, the Indiana State Medical Association organized a Scientific Exhibit for its annual meeting, the first such in the United States. The exhibit consisted of a display of pathologic specimens, rapidly growing in numbers until in the short space of two years, by 1899, it had reached a grand total of 800 specimens. The Indiana state association that year appropriated $300 to take the exhibit to the A.M.A. convention at Columbus, Ohio, where it attracted such great attention that this feature was adopted by the parent body as a permanent part of their program, and Indiana duly was credited for its pioneering enterprise. Individual members from every section of the state contributed to this effort. Democracy at work!

Let's look back just two years. Your association at the state level successfully negotiated a contract with the Veterans Administration which bears most favorable comparison with that obtained by other states; and, also during that same period, your Mutual Medical Insurance, Inc., was organized and became initially successful beyond every aspiration; all this because of unified support throughout our own Indiana. Democracy at work!

Now, pick up just a few threads of information and enlighten yourself re the activities of your state Committee on Legislation and Public Policy, along with the admirable cooperation it received from the many individuals of the constituent county societies, this during the past sixty days. You should be proud. The results speak loudly. Democracy at work!

Or, finally and briefly, study the background of your association leadership for the past ninety-eight years. *Stuffed shirts?* No! They were men, wholly without exception, thoroughly imbued with and versed in the fundamental principles of democracy at work. Yes, you have a *great* state association. It became so without *stuffed shirts.*

Sincerely,

Floyd L. Romberger

AMERICAN MEDICINE LOOKS TO THE FUTURE*

GEORGE F. LULL, M.D.†
Chicago

I WAS told tonight that I should talk about looking forward into medicine's future. In order to look forward into medicine's future I will have to go back into the past. You know a stock salesman, when he tries to sell you some shares of stock, always goes back into the earnings of the company, and what the stock has done, and then he projects that on into the future, so that he can show you, when you put $100 in his stock, what it will do in the future. So I want to go back into the history of the A.M.A. and organized medicine, briefly at any rate, and show you what things have been accomplished, and project them to a certain extent.

It was just one hundred years ago this year that the A.M.A. was established. The A.M.A. was established with one purpose at first, and that was to improve medical education in the United States. When Nathan S. Davis introduced a resolution into the New York State Medical Society it was for the purpose of forming a national organization to improve medical education. We have gone a long way in improving medical education. The men who established the organization in 1847 had the right idea, but most of those men were dead before great improvement in medical education took place. It is only in the last fifty years that this big improvement in medical education has taken place, until now we have only one school operating in the United States that has not been approved fully by the A.M.A. There are one or two others on probation, they haven't been fully approved, but the A.M.A. now is the referee, so to speak, of whether or not the student is receiving the proper type of medical education. All of us who have lived during the early years of this century realize that it has taken a great many years to establish the basis, and to set up standards that could be enforced in medical education. We now look with satisfaction upon the fact that we lead the world in medical education. I have seen the reports from the educators who went to Continental Europe after the war to examine the methods of education used on the Continent, and those methods fall far behind the methods used in this country. The men being turned out today in the United States are far superior to those turned out by the medical education system of any other country in the world.

Years ago the A.M.A. tried to get rid of patent medicines and tried to cut down quackery as much as possible. You know they had a lot of trouble doing this. They had a hard fight on their hands. The manufacturers of nostrums had unlimited financial backing, and the quacks were pretty smart fellows. They knew how to make money and they knew where to spend the money where it would do the most good. It was an uphill fight. They were hounded at every turn. Some drug manufacturing houses fought us because they did not want to go out of business, as they thought. At the present time this fight is at the stage where the reputable pharmaceutical manufacturing houses back the A.M.A. and the Council on Pharmacy and Chemistry at every turn. They are the people who are proud to have the Council of Pharmacy and Chemistry pass upon their products, because they don't want to put a product on the market that hasn't been approved by the Council. They want the products approved, and they are the best friends the A.M.A. have in commercial life. These were the people who fought the Council in the early days. Now the Council is still being fought by a very few firms who do not make reputable products. All products advertised in our national journal and in the journals of the state societies are approved. We now have all state society journals in the Cooperative Medical Advertising Bureau except two. These two states will not come into the Bureau, mainly because when they do come in they must refuse advertising which has not been approved by the Council.

The Journal of The American Medical Association was not thought of back in 1847. It did not start until 1887. Medical journalism in 1887 was a free-lance job. There were two or three in Philadelphia, and two or three in New York, all privately owned, and they had editorials in them that would make the *Chicago Tribune* look like the *Christian Science Monitor*, because these fellows mentioned names, they didn't pull their punches at all, and they talked about each other. Some of these editors thought that the national association could not succeed, nor could it support a national journal. This has been disproved by the fact that now *The Journal of the American Medical Association* is probably the best medical journal in the world, with a weekly circulation of over 130,000. This is only one of the publications that your national organization publishes, but it is the largest. One hundred thirty thousand copies of *The Journal* go out from headquarters every week. *Hygeia*, the journal published for the laity, now has a circulation of 200,000 per month, and we could double that circulation without any trouble if we could get the paper. We are allotted a limited amount of paper per month, and we use all of it in our publications. *The Journal of the American Medical Association* uses most of it. *Hygeia* uses about fifteen to twenty tons a month,

* Presented before the Secretaries' Conference in Indianapolis, January 12, 1947.

† Secretary and General Manager of the American Medical Association, Chicago.

and the special journals, like the *Archives of Internal Medicine*, et cetera, use the rest. There is a saturation point to be reached. The A.M.A. Journal now goes to 130,000 subscribers. There are less than 200,000 doctors in the United States, many of whom are not actively engaged in the practice of medicine, nor are they teachers, and for that reason are not interested in *The Journal*, but *The Journal* does not reach every doctor. It reaches the majority of them, but there are still many physicians who never see *The Journal of the American Medical Association*, and I doubt very much if most of these men are practicing a good brand of medicine.

In the early days we gave little consideration to what we call public relations. Public relations was something that had not been heard of as a profession. It was limited in the early days to the best public relations expert in the United States; namely, the practicing physician. His contact with the patient built up the public relations of the medical profession in the United States. He worked and his patients appreciated what he did, and I maintain that at the present time one of the best public relations contacts we as physicians have is the contact between the physician and his patient. If you are good the patient knows it, and the patient, knowing that you are good, has respect developed for the entire profession. Industry as a whole has built up this public relations idea, that you must have a paid agent, who has a certain technique of his own, and certain techniques common to public relations experts in general, which he will utilize to exploit our public relations. This profession has grown up in the last few years, and it is growing now by leaps and bounds, and all the public relations man wants is money to spend. This advertising sometimes may not be so good, because after all the public relations expert is nothing more than a man who gives you good publicity. If he gives you poor publicity he is not a public relations expert, because a public relations expert gives you only good publicity, and these techniques being utilized to exploit the medical profession may rebound and may cast discredit in certain places upon the profession, unless care is exercised.

At headquarters we have tried to develop adequate public relations support to our program. This development has gone on only in the last few months, so that you have not been able to see or hear of any of it in the field. The county secretaries, members of the House of Delegates, and others, soon will receive a news letter from my office, telling what is going on in headquarters; that is, the things we think you are interested in. If any of you have any criticism to make, or if you know of some way this letter can be improved, I would deeply appreciate your telling me how it could be improved. I may not be able to do what you wish, but I will try. We feel that you people in the field, down at the grass roots of organized medicine, are entitled to know what goes on at your headquarters and we will try to tell you. Many things go on that become too involved for a brief news letter, but we shall keep you advised as well as we can of what is going on at national headquarters.

In the last year we have developed our Bureau of Medical Economic Research. Doctor Leland did a splendid job, and suffered a stroke because of overwork for the association during the war years. He had one assistant, who was called into the service, so that there remained no Bureau of Medical Economic Research. We have revitalized this bureau. We think we were fortunate in finding one of the best economists in the country, and he is developing a Bureau of Economic Research. You will not see much put out by this bureau for several months, because the process of organizing the bureau has taken a lot of work, and the productive activity of the bureau will be curtailed.

Pursuant to a resolution introduced in the House of Delegates, we have developed a Committee on Emergency Medical Service. This committee, headed by Doctor Bortz, of Philadelphia, is attempting to formulate some plans for the utilization of medical manpower, should another national emergency arise. The committee has sent out a questionnaire to all men who were in military or naval service, asking for their opinions. The response has been wonderful, so the people who know about questionnaires say. Doctors are sending them back and expressing their opinions. In addition to the questions checked, there are two or three places where you can express an opinion. The only difficulty we have had with it so far is that doctors cannot write so you can read it. The girls who are trying to code these questionnaires have to devote a lot of time to the answers of these questions because they have to decipher them before they can code them, and they have the greatest difficulty in reading the doctors' handwriting.

Then the House of Delegates authorized the appointment of a committee known as the Committee on Rural Medical Service, of which Doctor Crockett, of your own state, is chairman. This committee has been very active. You may not know how active unless you have been particularly interested in it. Doctor Crockett has had additional men appointed to the committee, so they could divide the rural areas in the United States and have each man responsible for a certain region. This committee has met with farm groups and it continues to meet with them. It is a question of missionary work, and this committee has done an excellent job so far. We will publish future results in the news letter.

The Bureau of Information, established by the House of Delegates, was designed to help the returning veteran. Of course, we are over the hump as far as veterans are concerned, but we have thousands of inquiries, both by letter and in person, from veterans who are seeking places to practice in the United States and want information about

them. The county and state societies furnished us with their needs and certain data about where men were needed in these areas, and we tried to pass it along to the men coming out of the service.

There is a Bureau of Health Education, but you probably know very little about its work. It has done a splendid piece of work for the good of the people in the United States. They have carried on a campaign of education through the schools, they have a joint committee with the National Educational Association. This joint committee has published the textbook for the teachers of health education in the schools throughout the United States. This book has been in use for a number of years and needs revision badly at the present time, so the Board of Trustees appropriated a certain sum of money, with a like sum being appropriated by the National Education Association, to have this book revised. They have sold thousands of copies and it is the standard textbook in use all over the country. It is the Bureau of Health Education which makes arrangements for our radio programs. These programs have had hard sledding because they are on Saturday afternoon, and have to compete with athletic programs and sometimes with the philharmonic orchestras. We are getting a spot on another national program, on Monday night, where we have practically no competition. It will be a program to glorify the American Doctor. It will be a series of dramatized events in the life of a fictitious doctor in a moderate-sized community. This will go on, I think, at 9:30, Chicago time. The radio chain is trying to get us to put on the program on another national chain, so that we will have programs on all three national chains taking place every week. This is not propaganda or public relations. That comes in as a secondary thing. It is for the education of the public. It will cost the A.M.A. many thousands of dollars to put them on, notwithstanding the fact that radio time has been donated in all cases. Another thing many county secretaries may not know is that we have available platters of material which can be issued to you for use on local radio stations. We shall gladly supply you with these platters, and you can find out from the Bureau of Health Education the subjects covered. We can supply them on a weekly basis, so you can arrange with your local stations to have a weekly program sponsored by the county medical society.

The Council on Medical Service has been working hard, mostly with prepayment plans. The history of insurance against sickness is a complicated one. It is comparatively new, although out in the Northwest they had prepayment plans twenty years ago. They weren't generally established. During the past year the number of people covered by prepayment insurance, as sponsored by medical societies, nonprofit prepayment plans, has increased 100 per cent. Life insurance in this country probably is the best in the world; the average citizen is better protected by life insurance than any other individual in any country. This did not occur over night. It was built up over several generations, so that our enemies cannot expect us to build up this prepayment sickness insurance over night. It will take time, but with a 100 per cent increase in one year I believe we are on our way to give the American people something that will be of great value to them, and will protect them against the expenditure of large sums for catastrophic illnesses. The Council on Medical Service has sponsored regional meetings in various parts of the country, which have been very successful.

You may know that the Board of Trustees, pursuant to a resolution in the House, has authorized a meeting of County Secretaries in Atlantic City on the Sunday preceding the convention. The regular convention will open on Monday, but on Sunday, in the afternoon, there will be a meeting of all county secretaries who are in Atlantic City. On January tenth the Board of Trustees authorized the appointment of your Doctor Mitchell as secretary of this conference governing the entire United States. The Trustees knew of his work and the interest Doctor Mitchell has shown, and they want him on the program at Atlantic City, where he will have a workshop like a conference, where there won't be one or two "big shots" to tell you something, but where you tell each other something, because you all learn from each other a great deal more than you learn from some man brought in to tell you something that may or may not be interesting. We hope this workshop type of conference will be a success and perhaps we can carry it on and have one each year, so that the county secretaries can get to know each other and know their problems, and can express themselves in these meetings.

The Council on Industrial Health, which was unthought of fifty years ago, is now very active. Projecting their work into the future, we know that one of their problems will have to do with the health setup in the coal industry. You know that there is a huge welfare fund and a health fund being set up in the coal industry. According to the contract made between the government and the miners union, part of this fund will be derived from a check-off of the miners' pay, and part from a tax on the tonnage of coal issued by the mining company. This will demand a medical service which may be uniform throughout the coal region or may not be. We don't know. A naval officer was operating the coal mines for the government when the operators took over, and he appointed Admiral Joel Boone the head of a committee to make a survey of the coal mining industry, as far as health activities were concerned. Admiral Boone's report has been in preparation for several weeks. The field work has been done. The Council on Medical Service and the Council on Industrial Health have worked with Admiral Boone and have given him advice when asked; they have been to Washington and have met all of the men engaged in the field survey. This report

will probably be very illuminating and it will call for a lot of drastic changes in the medical service to the coal mines.

Now, looking forward in general, life has become a great deal more complex than it was fifty or one hundred years ago. We now have many more problems to deal with than we had then. Looking back into the history of the A.M.A., we found that as long as the doctors, meeting together, discussed scientific medicine, there was no argument. They were united for the best type of scientific medicine. When the issue of the medical schools and medical education came into the picture there was trouble; they argued; they fought with each other about various questions about medical education. When many other things have been brought into the picture we find that the ship of state of the A.M.A., or of organized medicine, has not gone on with quite the even keel that it should. There probably has been a little blowing from various quarters, so that the ship has not sailed smoothly. Now we have the problem of the medical profession going into business. We have these prepayment insurance plans, medical societies are becoming business-minded, they are going into business, and we are having trouble now and we will have for some time, until we get all of the angles of this prepaid insurance ironed out and find out the best way to run it. It is all experimental. The insurance companies didn't want to experiment with sickness insurance because they had no actuarial experience. They kept away from it and then the doctors finally put it on the table and said "We will take a flier at it," and for the most part they have been successful in running this type of insurance. There are lots of places where this can fall down, lots of places where they might have trouble, and those things we have to guard against. We have to watch that we do not have too much trouble, because once you start having trouble with these prepayment plans the public will wonder whether or not you can run a prepayment plan and whether or not you know anything about the insurance business. The insurance companies have shown more interest since the doctors have started these plans, and they now see that there may be a field for all of them and for the prepayment plans as well. It is going to be a question of years. Probably many of us will not live to see this thing ironed out properly, but I have no doubt in my mind but what it will be ironed out properly, without the help of any government bureau.

We are looking forward to legislation which may affect the practicing physician in the United States. We believe that any legislation passed at this Congress will not be as bad as we might have expected in the last Congress. We feel that the tenor of Congress this time will be more toward the lines of normalcy than the last Congress was. We feel that these New Deal ideas that many of us looked upon with skepticism are going to be held in the background. But gentlemen, there may come a time when these may come to the surface again, and we always will have to be ready to have a united front to present against them; and now that we have friends in Congress, who are willing to back us up with something that we want, we should see that adequate legislation, satisfactory to us, is proposed to Congress. It is not up to us to pass the legislation, it is up to our legislators, but our legislators are perfectly willing to listen to organized medicine, if we will get together and tell them what we want. They depend upon us to tell them what we want and if they approve it, I believe that there is a reasonable possibility that some legislation will be passed in this Congress which will cover certain phases of the practice of medicine which were covered in the Wagner-Murray-Dingell Bill too well and incorrectly, as we thought.

Now, in going around the country as I have for the A.M.A., and meeting people all over the country, as well as many old friends in various places, there is one thing that strikes me as being very peculiar. We have a profession of 200,000 people in the United States, and only a few thousand of them do the work for that profession, as far as organized medicine is concerned. It would appear to me that out of the 200,000 physicians in the United States 10,000 do the work and the remainder do the crabbing. You know that down in your local societies. They will tell you what you did wrong and what you should have done, but they won't come out and take an active interest in the organization. Not long ago I had a man say to me, "What has the A.M.A. ever done for me?" I said, "Before I answer that question, I will ask you what you ever did for the A.M.A." He said, "Why I have been a member of the A.M.A. for fifteen years." I said, "What dues did you pay; were you a Fellow or a member?" He said, "I didn't know there was any difference." I said, "There is quite a bit of difference." He said, "I don't know what I was; I think I was a member." I asked, "Did you have a pocket card?" He said, "No." I said, "Then you were a member. A member of a state organization pays no dues to the A.M.A., so you never spent a cent of money." He said, "I subscribe to *The Journal;* I spend $8.00 a year on *The Journal.*" I said, "You get the best journal published in the world, and you get twenty-one cents worth of paper; without a bit of ink on it, it costs twenty-one cents to furnish the paper for one issue. Do you ever go to your county society meetings?" He said, "No, I go once a year, to the dinner meeting." The rank and file of us react just about like that. Let George do it; he goes to the county society, he is a good work-horse, he is a friend of mine, and anything he says, goes. But let George do the least, little thing he doesn't approve of, and he is going to come down on George. I don't know of any way by which you can stimulate membership in organized medicine to take an active part in it. Even if they don't agree with you, it would be fine to have them come

out and take an active, rather than a passive part, in the organization.

Now we are looking forward to our centennial year in Atlantic City. This centennial is going to bring out a lot of doctors. So far as hotel reservations are concerned, we have had an enormous number of people apply for reservations. We are looking forward to having the biggest meeting in the history of the organization, but even so, if we have 15,000 men register, what a small proportion of the 130,000 members it is at that. It is a very small proportion, and I don't know what can be done about it, but we simply must stay together and present a united front on any objectionable legislation that may be introduced into the next legislature. Probably we will have a chance to appear and say what part we have approved or disapproved. It may interest you to know that the state medical associations were invited to give us an opinion on the things that could be corrected in the Taft Bill. A good many, very valuable changes were suggested by Doctor Romberger's committee here in the state of Indiana. We have tried to get them to the people who want to know about it. This isn't any high pressure thing that we are doing. The objective of the A.M.A. is to see that if any legislation is passed it will be of a suitable type to improve the medical care of the people in the United States. That is all we are after. We are not trying to sell anything. We are not going to high-pressure anything, but we believe we are in a position to approach our legislators and tell them our opinions. This will go on in the next Congress, and probably the Congress after that, so that we probably are going to have beneficial legislation passed that will improve medical care throughout the United States and will not drag it down to a much lower level than exists at the present time.

I thank you for listening to me this long, and I appreciate being invited here.

THE NURSE SHORTAGE*

MISS E. NANCY SCRAMLIN‡

MUNCIE

THE basic factors underlying the nurse shortage have been so thoroughly discussed in the past few years that it is perhaps unnecessary to recall them here, but just so we may be sure we are all viewing the picture in the same perspective, may I take the liberty of sketching a background with a few pertinent facts?

We all are aware that this shortage of personnel is not confined to the nursing profession. Fifty years ago the only professions open to women were teaching and nursing. In this economic era practically no vocations are closed to them, and in the present striving for economic security the majority of girl high school graduates plans to acquire skill in some field even though matrimony is the ultimate objective. Hospitals lack not only nurses, but doctors, dietitians, maids, and clerks. The teaching profession is equally desperate. Last year one of our state teachers colleges had, through its placement agency, calls for 2,888 teachers. In June of that year the college graduated 120 new teachers. The labor market is tight.

Secondly, any nurse shortage must be viewed in terms of the economic condition of the country. If another 1929 market crash should precipitate us into a depression such as we experienced in the thirties the nurse shortage would become a myth. Domestic help would be available and the big reservoir of married nurse homemakers could be tapped at our desire. But no one wishes the nurse shortage to be alleviated by any re-enactment of 1929.

If figures have any special value in this headache, the National Nursing Council estimated that there were 317,000 graduate nurses actually or potentially available in August 1946. They also estimated that at least 350,000 were needed, leaving a shortage of 41,000. The need is numerically greater in hospitals but also exists in public health, nursing education, and other fields as well. Those potentially available include 35,000 estimated as graduates in 1946, and 37,900 nurse veterans, neither of which groups can be relied upon 100 per cent. Many weary nurse veterans are taking a vacation from nursing—some temporarily and some permanently, and the marriage rate among young graduate nurses is high—especially in this post-war period. *The Saturday Evening Post,* in its plain-spoken article of January fourth, estimates the shortage between 65,000 and 75,000.

There is, moreover, every indication that the demand for nurses will increase rather than decrease, for the following reasons:

1. The government plans to spend $375,000,000 for hospital construction in the next five years. New hospitals must be staffed.

2. In public health, minimum requirements for preventive and health supervisory services call

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‡ President, Indiana State Nurses Association.

for a ratio of one public health nurse to 5,000 population. The number should probably be doubled to provide public health nursing care for the sick in their homes. At least 7,000 more are immediately needed. There are over 900 counties in the United States which have no public health nurse.

3. Voluntary health insurance plans make it easier for more persons to seek hospitalization.

4. The tendency of American families to live in smaller quarters and the frequency with which all adult members of the family are employed make it difficult to care for illness, either acute or chronic, in the home.

5. The increase in the number of elderly and infirm who need nursing care.

So much for a brief summary. More nurses are needed. The present problem is to attract more well-qualified young women to the profession of nursing. In order to develop a program for accomplishing that objective there are two important areas that need careful study.

The first area concerns the student nurse and the decreased enrollment in schools of nursing below that of prewar years.[1] If continued for another year or two the outlook in the nurse shortage can be grave. Not only are students entering in insufficient numbers but the percentage of students that drop out is regrettable; this in spite of tests and measurements designed to help select the girl most likely to carry through to graduation. A happy, satisfied student is an asset, both to her school and to her profession, and inestimable damage can be done by the discouraged nurse who drops out at the end of her pre-clinical period or first year. Many persons believe that hospitals exploit student nurses and this opinion, unfortunately, was intensified during the war years when graduate nurses were scarce and hospitals overcrowded.

Too many girls, even in so-called normal times, find student life in a hospital a disillusionment. They think of nursing school as a college experience and find they are confronted, not only with an academic program, but with many hours of ward responsibility. When students criticize schools of nursing the thing they attack most is the matter of fatigue. You and I know there is a threshold of fatigue beyond which none of us works effectively. In the average hospital too many nurses, students and graduates, work constantly too near that point. The element of fatigue is an important factor in causing young women to fail in the nursing profession.

Social programs in the average school of nursing are usually inadequate for the need of the college-age student. They live in dormitories and their work is largely under the supervision of women—not too good a situation when one of the most important factors in their lives is having the opportunity to enjoy social contacts with men.

Another serious problem is that of the exposure of the young student to dissatisfied and unhappy graduate nurses. Registered nurses are human beings, and we are not all Florence Nightingales, by any means, but long hours and other inadequate personnel practices do not make for greater harmony, efficiency, and idealism. As long as young nurses are exposed to these adverse conditions it will be difficult to enroll and retain new students.

The student nurse, eighteen or nineteen years of age, is seldom a mentally mature person. Our present trend to small families, the prolonging of education, and the dependence of the child probably have a tendency to retard the mental maturing of the adolescent. When the young nurse is thrust into responsibilities such as she has never met before she may often experience severe nervous strain. More emphasis on mental hygiene and more opportunities for expert counselling would save much of the loss to schools of nursing.

There is considerable thinking, both in lay and in professional groups, that perhaps nursing should be taken out of hospitals, made a four- or five-year college curriculum, and placed in tax-supported institutions.[2] Nursing is a public service. Why should it not be provided for the same as education for teaching, which is also a public service. In such a program all class work would be on the campus, with the student assigned at stated intervals to certain hospitals for definite clinical experience and only of sufficient length for her to gain proficiency in that particular field. There is another viewpoint, according to *The Saturday Evening Post:* "The Greater New York Hospital Association is planning a campaign to lower the educational requirements in its state. It is confident that besides turning out nurses who would be happy at the bedside, a shorter, more utilitarian course would attract a greater number of girls to nursing." The National League of Nursing Education and the American Nurses Association have spent the past fifty years in raising the requirements for admission to, and the curriculum of, the training school in order that nurses can serve the doctors more efficiently in the ever-expanding field of medical science. The merit of the Greater New York Hospital Association is, therefore, open to serious question.

The second area of trouble in the problem of the nurse shortage concerns graduates. It involves salaries, personnel policies and practices. There are many nurses, especially the indispensable hospital staff nurse, who feel that employment policies in the average institution are in a sad state—that the nurse is one of the forgotten persons in this present economic struggle. To illustrate this situation I would like to quote some figures and opinions collected by an Ohio nurse, Miss Edna

[1] Why Do Students Drop Out? Middlewood, Esther L., *Am. Jnl. Nursing,* Dec., 1946.

[2] Alternating Theory and Practice. Groff, Hazel A. and Woodbury, Marion. *Am. Jnl. Nursing,* Mar., 1946.

Sharritt, who contacted three hundred nurse veterans in forty-eight states.[3] Questionnaires returned by one hundred fourteen of them indicated that only fifteen were returning to their prewar positions. Of the fifteen, four stated that they were returning because they felt a sense of obligation to the hospital. Three felt it was easier to return to a familiar situation, and six wanted to be in the city with their relatives or friends.

In most instances, however, it was noted that the personnel practices at the hospitals to which they were returning were good, as indicated by the following comments: "The hospital is new, modern, well-equipped and well-staffed." "The salary is adequate, with provisions for increases; there is a four-weeks vacation with pay; the residence provides comfortable living, although nurses may live out if they choose." "Salary is good; four weeks vacation with pay; 44-hour week; an opportunity to advance; the administration is cooperative and interested in the welfare of its employees."

Of the ninety-nine nurses who did not return to their previous positions, forty-six gave reasons specifically related to personnel practices, and an analysis of their reasons reveals that thirty-two felt that the salary was too low and not in accord with the present high prices. Others felt that vacations were too short and not in accord with professional standards. The vacation plan showed considerable variation. One nurse received fourteen days in three years; one received two weeks with pay after three years' employment; three received one week with pay; one received one month without pay. Many felt the health program to be inadequate and all mentioned inadequate sick leave. Other opinions expressed were: "Most institutions do not provide any security for old age. The hours are often long and irregular and the time off is felt to be inadequate for normal adjustments and living. We often find women in other fields of employment receiving better salaries, more time off, and having less responsibilities. The salary is often less than that of unskilled laborers." They also comment that general staff nursing is not given the respect and dignity to which it is entitled, but is often considered by administrators to be the lowest type of nursing one can do. Yet it is the very essence of the nursing profession—bedside nursing. Many women find bedside nursing a very satisfying vocation, and without doubt the problem of shortage in this area would be materially lessened by better personnel policies.

Perhaps this questionnaire sampling is too small to be of great value. It seems to indicate, however, that many more nurses would be interested in hospital positions if personnel practices were improved.

No discussion of the nurse shortage would be complete without considering, even briefly, the role of the so-called practical nurse in the care of the sick. It is estimated that there are at least half as many of these as graduate nurses, and few have had any formal training. The fact that they often work side-by-side with graduate nurses, have much less responsibility, and often receive almost equal or equal pay, has not made for improved relationships between employers and professional nurses.

The American Nurses Association has gone on record as believing:

1. All persons working in the field of nursing should be trained; and
2. Schools for practical nurses should be set up in an educational rather than a service or hospital environment.

The United States Office of Education has long been interested in this problem of training practical nurses and is ready to cooperate in putting such a program into operation, through the public schools. If schools for practical nurses should be set up now would there be applicants for the course? This is an important question when many hospitals are so desperate for help, and when any woman who wishes to call herself a practical nurse not only can find work, but pretty largely dictate her salary.

There is some thinking that the Nurse Practice Acts should be amended to require that all who nurse the sick for hire be licensed. To date, New York is the only state with such a statute, and we understand that it has been difficult to administer and that the Board of Regents of that state is asking for its repeal. Indiana is one of the nineteen states whose Nurse Practice Act provides for the licensing of practical nurses under the title of "Trained Attendant." The Indiana State Nurses Association now has a special committee currently working in conjunction with the State Board of Examination and Registration of Nurses on this problem.

To insure adequate graduate nursing service for the future the American Nurses Association, at its recent Biennial, approved: "Greater development of nurses' professional associations as exclusive spokesmen for nurses in all questions affecting their employment and economic security. Such development should be based on past successful experience of professional nurses' associations in collective bargaining and negotiation."

I cannot, of course, speak for the 10,000 registered nurses in Indiana, or even for the 4,000 members of the Indiana State Nurses Association, for we have not met in convention since the adoption of the above point last September. It is my personal hope that such action will not be needed in Indiana. We feel that we have a fine working relationship with the Indiana Hospital Association and we hope that these problems which concern us jointly can be solved to the satisfaction of both organizations.

[3] Where Are the Ex-Service Nurses? Sharritt, Edna E. *Am. Jnl. Nursing*, Dec., 1946.

Just how extensively labor organizations have influenced nurses we can only guess. According to one report the C.I.O. and the A.F.ofL. jointly claim 11,500 members. Recently one of our industrial nurses spoke to a group of senior nurses. Without the speaker mentioning the subject the students asked what the professional organizations were doing about wages and hours for graduate nurses. Perhaps those of us who are older reckon without the hard-headed realism of some of this younger generation, who have grown up in homes where fathers and brothers have been union members and where collective bargaining has been freely discussed.

What is the final solution of the nursing shortage? The problem must be viewed in the long perspective. It involves much more than where and for how long we shall train student nurses, or what the hours and wages for the graduate shall be, important as these matters are. The long-range program must be one of education.

The public needs to be educated. It needs to take the time and trouble to become acquainted with local hospitals, schools of nursing, and health agencies. Nursing is a public service and citizens of every community are entitled to both good and adequate nursing care. They should know what good nursing care is and insist upon having it when they need it, or find out why it is not available.

All of us, and certainly all nurses, need to talk more about what is good about nursing. Too much has been said that was unfavorable. Nursing is an emotionally satisfying vocation to many women. There could be no finer preparation for marriage. If it can also become a profession that offers economic security and opportunities for normal social living, it should be one of the top vocational attractions for the high school graduate.

Doctors can help immeasurably by talking to patients and daughters of patients about nursing as a vocation, or by lending their prestige to career-day programs which many high schools sponsor.

If all of us concentrate on this problem, perhaps in the not-too-distant future the overworked medical profession, instead of rolling up its sleeves to pinch-hit for the non-existent nurse, can roll them down more often and find time for at least the Sunday paper.

PHYSICIANS REQUIRED TO REGISTER UNDER NEW LAW: A REPORT ON 1947 LEGISLATURE

By Committee on Public Policy and Legislation*

Indiana medicine got mostly what it wanted . . . and didn't get what it didn't want . . . from the 85th General Assembly, a record which indicates the profession is held in high esteem by the state administration and the individual senators and representatives.

The session saw further expansion of the public health program which had its inception in the 1945 legislature. Again, with the blessing of Governor Gates, nearly all bills drafted and shepherded by the State Board of Health were enacted into laws. The Indiana State Medical Association gave its support to the board's program and continued its position of leadership in advancing the cause of better health for the people. Dr. L. E. Burney, state health commissioner, reviews the public health legislation in an article elsewhere in this issue.

While interested in particular in two bills authorized by the House of Delegates, the profession, nevertheless, gave its attention to all constructive health measures. By supporting these bills your legislative committee strengthened its position with the legislators. The committee was consulted frequently about the merits or demerits of certain legislation. We were looked upon as advocates of bills which were good for the public health, and not as selfish "objectionists."

BILL PROVIDES FOR LICENSING OF NATIONAL BOARD DIPLOMATES

The two bills introduced at direction of our House of Delegates will have a profound bearing upon the practice of medicine in our state. One makes amendments to the Medical Practice law, and the other requires annual registration of all licensees of the State Board of Medical Registration and Examination. The bills passed with virtually no opposition.

The principal purpose of *Senate Bill 212* is to give the medical registration board authority to accept examinations certified by the National Board

* Committee on Public Policy and Legislation—Co-chairmen, Norman M. Beatty, Indianapolis, and J. William Wright, Indianapolis; George Daniels, Marion; J. R. Doty, Gary; Harold J. Halleck, Winamac; O. T. Scamahorn, Pittsboro; Robert L. Glass, Indianapolis; John M. Palm, Brazil; Walter F. Kelly, Indianapolis; A. N. Ferguson, Fort Wayne.

of Medical Examiners in lieu of its own annual examination. Some criticism has been directed at the law in the last few years because the board did not have funds to give more than one examination a year for licensure, and doctors who held licenses in states with which Indiana does not have a reciprocity agreement were compelled to wait some months for examination. The new law remedies this situation.

The other amendments were mostly technical except that the per diem of board members was increased from $6.00 to $10.00. *Senate Bill 212* passed the Senate 31 to 0 and was adopted in the House 67 to 0.

ALL BOARD LICENSEES MUST REGISTER ANNUALLY

Senate Bill 213 provides that each practitioner of the healing arts licensed by the state medical registration board must register annually and pay a $5.00 registration fee. Non-residents of Indiana will pay $10.00 instead of $5.00. When our House of Delegates gave its approval to such a measure, it recommended the fee be set at $2.00, and this was the amount incorporated in the original bill. The House Committee on State Medicine and Public Health increased the fee over vigorous protests of our committee.

Under terms of this new law all board licensees must register by August 31, 1947. Those who fail to comply will automatically lose their licenses, but the license may be reinstated by payment of the delinquent fee and an additional $10.00 penalty fee. The penalty was doubled from that in the original bill by House committee action. Beginning next year the registration fee will be due on or before June 30, 1948, but licensees will have until August 31 to register before becoming delinquent.

Enactment of this bill will give the medical registration board a registry of all persons licensed to practice the healing arts, something which has been badly needed in Indiana. Too, it will uncover those who are practicing without a license so they can be prosecuted.

The money from the registration, subject to appropriation by the State Budget Committee, will provide the board with funds to hire investigators for enforcement of the Medical Practice Act, office personnel, et cetera, and performing its other duties. The board should be financially able to prosecute the quacks who are now preying upon the sick.

When the House committee upped the fee to $5.00, the argument used for doing it was that the charge was in line with registration fees of other state professional boards. However, before agreeing, the Committee on Public Policy and Legislation made a telephone poll of officers and councilors of the association and with two exceptions, was directed to "go along" with the committee.

The bill went through the Senate 33 to 0 and passed the House 66 to 1.

MUST REPORT VICTIMS OF EPILEPSY

The legislature, in passing *House Bill 30*, assigned a new responsibility to the medical profession, a move designed to prevent possible tragedies on Hoosier streets and highways.

This law requires physicians to report to the Board of Motor Vehicles, through the State Board of Health, within ten days after diagnosis, any cases of epilepsy or similar lapse-of-consciousness disorders. The information will be confidential. These reports will be used by the motor vehicle department to determine the eligibility of any person to operate a motor-driven vehicle. Any doctor who fails to report such cases may be guilty of a misdemeanor and punishable upon conviction by a fine not to exceed $100.00.

This legislation is the aftermath of an accident in Indianapolis in June, 1942, when three persons were killed and several injured when an auto driven by an alleged epileptic victim careened over a sidewalk and into a crowd of shoppers.

IMPROVE FACILITIES FOR MENTALLY ILL

The legislature of 1947 will long be remembered for its action in providing better care and treatment for the mentally sick. Three and a half million dollars were appropriated from the state's postwar construction fund for building a 250-bed, LaRue D. Carter Memorial Hospital, a screening institute for mental cases, near the Indiana University School of Medicine. It will be not only for treatment, but will serve for training mental hospital personnel, and for the study of psychiatry. The medical school plans to use the hospital in giving a postgraduate course in psychiatry.

The Indiana Council for Mental Health, three of the five members of which are physicians, will supervise the new screening hospital and all other state hospitals for insane, feebleminded and epileptics. All public clinics dealing with mental diseases will come under the council through legislative action. The $6,000-a-year salary ceiling on physicians in state service was increased to $10,000, subject to approval of the Governor and Budget Committee.

All activities of the Welfare Department in relation to mental cases, including clinics in psychiatry, were transferred to the council.

Funds were appropriated for the construction of the new Northern Indiana Hospital for the Insane at Westville, Indiana, and the transfer of the hospital for the criminal insane, now a part of the state prison at Michigan City, to the new Westville institution was authorized.

CHIROPRACTIC BILL DIES IN COMMITTEE

The chiropractors made their usual biennial attempt to establish a licensing board of their own, with educational standards for licensure below

those required by the medical registration board. The chiropractic bill, *House Bill 174*, was introduced on January 27, and assigned to the House Committee on State Medicine and Public Health, where it died, but not until the author, Representative Herbert N. Copeland (Jefferson-Scott) made two unsuccessful attempts to "blast" it out of committee. The vote was 68 to 15, and 51 to 12, for the bill to stay in committee.

The chiropractors' lobby waged a hard battle for this bill, using a new technique. It was the "do something for a veteran" approach. Some six hundred students studying chiropractic under the G.I. Bill of Rights at an Indianapolis chiropractic college flooded legislators with hundreds of appealing letters and swarmed State House corridors and the house floor to button-hole representatives. They even marched on the Governor's office to solicit administration support. It was the greatest organized pressure campaign the chiropractors have ever employed. They jammed the house chamber at a public hearing on the bill, heckling opponents, and cheering wildly at remarks of their own speakers.

Medicine presented its side of the controversy by issuing an original pamphlet entitled "Why Indiana Doesn't Need a Chiropractic Board" and reprinting a *Hygeia* article which exposed chiropractic as a science of healing. Work of your legislative committee, attorney and executive secretary in contacting legislators in person, and contacts made by the county medical societies, and the individual physicians, was effective in defeating this bill. Particularly helpful in combatting the "G.I." appeal was a petition against the bill signed by World War I and World War II veterans of the Lake County Medical Society, and mailed to all General Assembly members.

One other cult bill was introduced. It would have created a board of naturopathy. The bill died in the Senate Committee on Public Health.

BILLS OF INTEREST TO MEDICINE WHICH BECAME LAWS

Bills passed and signed by the Governor follow: (Those marked emergency are now in effect. The others will become effective when the acts are published and distributed).

S. B. 1 (Van Ness-Balz)—Authorizes State Board of Health to cooperate with Federal government in construction or improvement of hospitals and to accept Federal money. Emergency.

S. B. 2 (Van Ness-Brokenburr)—Abolishes present state commissioner of weights and measures; transfers duties of the office to the State Board of Health. Emergency.

H. B. 18 (Edick-Henley)—Creates Commission of Physically Handicapped Children and provides for census of such children and co-ordination of public and private agencies having responsibility for them. Emergency.

H. B. 25 (Henley)—Authorizes second class cities and the counties in which they are located to establish combined city-county full-time health departments. Emergency.

H. B. 26 (Hiestand-Henley)—Authorizes counties to co-operate in establishment of full-time health departments; departments to be established after referendums; sets out duties and powers of the departments.

H. B. 29 (Leahy-Henley)—Enables state treasurer and State Board of Health to co-operate with Federal government and accept Federal allotments from the social security fund for health purposes. Emergency.

H. B. 30 (Malone)—Requires physicians to report to Bureau of Motor Vehicles by way of the State Board of Health within five days after diagnosis, any cases of epilepsy or similar lapse-of-consciousness disorders, information to be confidential; violation defined as misdemeanor, fine $100. Emergency.

H. B. 33 (Henley)—Empowers State Board of Health to establish and maintain branch offices throughout Indiana where necessary. Gives legislative authority for the operation of the board's division of industrial hygiene. Emergency.

H. B. 34 (Moellering-Hughes)—Provides for readmission and recommittal of discharged inmates of state schools for the feeble-minded to the schools on written application by a physician.

S. B. 43 (O'Grady-Porter)—Legalizes acts of county hospitals created under a 1913 act—later repealed without a saving clause—and places their management under the 1917 county hospital law; authorizes issuance of county bonds to finance improvements and additions for such hospitals. Applies to Sullivan County Hospital. Emergency.

S. B. 50 (Wolcott)—Places psychiatric services in state institutions under the Indiana Council for Mental Health and prescribes personnel rules for the service.

S. B. 51 (Van Ness-Moffett)—Amends 1945 Mental Health Council Act, placing under the council functions now under the Welfare Department with respect to mental health clinics, research in psychiatry and dissemination of mental health information. Emergency.

S. B. 60 (Van Ness-Balz)—Provides for appointment by the Governor of the superintendent of Northern Indiana Children's Hospital; provides the superintendent may be either a physician or graduate of a hospital administrative school. Emergency.

S. B. 82 (Gardner-Van Ness)—Authorizes the Governor to appoint trustees for Northern Indiana Hospital for Insane for four-year terms; gives trustees entire supervision of the institution, including authority to fix compensation of superintendent; places all employees under a merit

system; makes it a misdemeanor to solicit campaign funds from them; creates a division for criminal insane in the hospital. Emergency.

H. B. 88 (Conrad-Malinka)—Increases to $1.50 a day the amount that state, county and city-owned sanitariums or hospitals shall be entitled to receive from the state for tuberculosis patients. Emergency.

S. B. 119 (Matthews-Van Ness)—Permits treatment of indigent patients in local hospitals instead of only at Medical Center in Indianapolis. Emergency.

H. B. 120 (Downey-Tinder)—Gives board of managers of county tuberculosis hospitals power to appoint hospital superintendents and to receive and administer gifts, donations and bequests. Provides that such acquisitions shall not be taken into account and expended in the preparation of the budget. Emergency.

S. B. 212 (Balz-Kendall)—Increases per diem for medical registration board members from $6 to $10 a day; removes authority to employ clerk as such and provides for hiring personnel whose duties are to be assigned; authorizes acceptance of certificates of answers of other boards as basis of approving applicants for licensing. Emergency.

S. B. 213 (Balz-Kendall)—Provides annual $5 registration fee for Indiana physicians, $10 for nonresidents; failure to re-register causes cancellation and $10 reinstatement fee is provided. Money received to defray cost of operating board. Indiana now has no annual registration for physicians. Emergency.

S. B. 230 (Coblentz)—Authorizes creation of building funds for construction of county hospitals; permits tax levy of 2 mills for the funds.

H. B. 246 (Colbert-Moseley)—Provides for instruction to be given in elementary and secondary schools on the effect of alcoholic beverages, tobacco and sedatives on the human body.

S. B. 248 (Coblentz)—Increases salaries of members of boards of county hospitals established under the 1917 Hospital Law as follows: chairman from $75 to $180 a year; secretary, from $50 to $150 a year and other members from $25 to $120 a year.

H. B. 254 (Malinka-Hunter)—Requires every health officer to be a licensed physician and that professional employees meet qualifications of the State Board of Health. Emergency.

S. B. 265 (Kendall-Wolcott)—Amends county hospital law mandating county council to appropriate proceeds of bonds authorized for hospital purposes and mandating appropriation of funds for payment of bonds. Emergency.

H. B. 296 (Malinka-Downey)—Requires State Board of Health and State Board of Education to work out a program whereby the services of all doctors, nurses, dentists, sanitary engineers and other specialists of the health board shall be made available to schools for advisory and consultant services.

S. B. 298 (Moffett)—Provides for commission to study communicable diseases among poultry and domestic animals and effect on public health.

H. B. 450 (Adams-Henley)—Re-writes the 1945 law relative to licensing private nursing homes. (The old law was found inadequate and in some respects unworkable.) Emergency.

PUBLIC HEALTH LEGISLATION ENACTED BY THE GENERAL ASSEMBLY

L. E. BURNEY, M.D.*

INDIANAPOLIS

DURING the recent session of the 85th Indiana General Assembly several public health measures were considered and enacted into law. The new Legislation plus that provided by the 1945 Legislature provides a basic structure on which a greatly improved health program may be developed for the state.

The 1945 Legislation applied, for the most part, to the reorganization of the State Board of Health, while a majority of the more recent acts pertain to health administration in cities and counties.

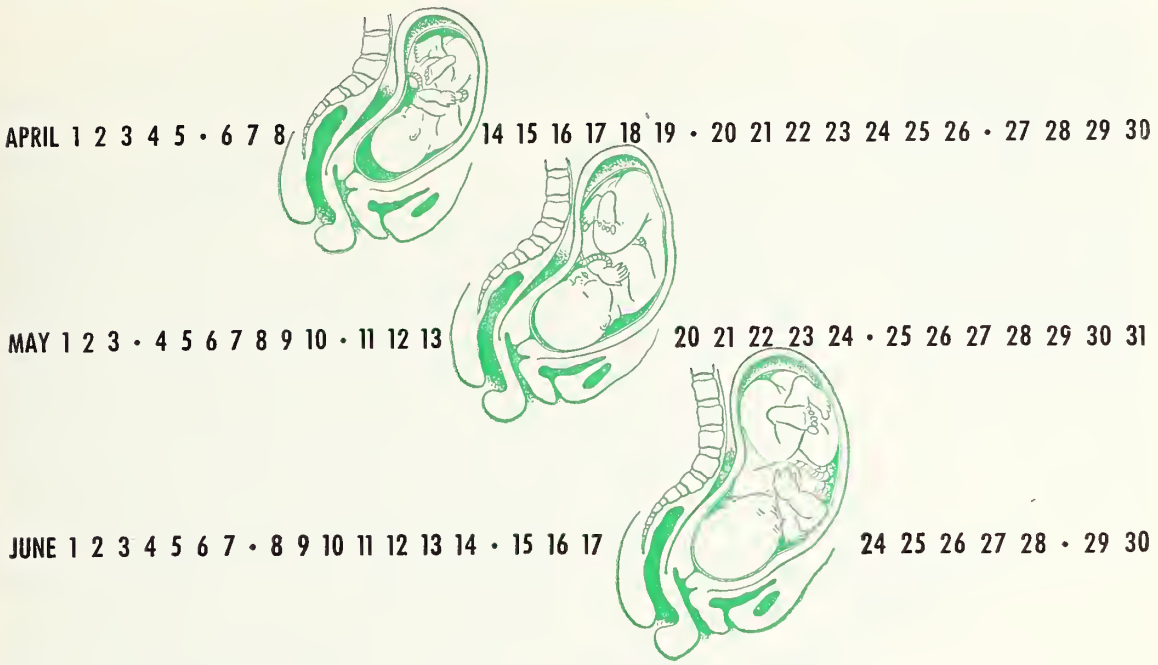
One of the bills *(H. B. 25)*, which became a law, makes it possible for a county and second-class cities within the county to combine for the purpose of establishing a city-county full-time health department. A bi-partisan board of health, consisting of seven members, is provided for. Three of the members, one of whom must be a physician, are to be appointed by the Board of County Commissioners, and the Mayor selects three additional members, two of whom must be physicians. The County School Superintendent, by virtue of his office, is the seventh member of the board.

The powers of the seven-member board include policy making, appointing the health officer, and approving professional employees appointed by the health officer.

The County Council shall, for the purpose of providing funds for the operation of such a health department, levy a tax upon all taxable property within the county but without the corporate limits of second-class cities. The Common Council of second-class cities levies the tax within their corporate limits.

Especially important to the future of public health in Indiana was the passage of *H. B. 26*, which permits any county, or two or more adjacent

* State Health Commissioner, Indiana State Board of Health, Indianapolis, Indiana.



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"SMOOTHAGE" MANAGEMENT

Pressure on the pelvic bowel by the enlarged uterus and impaired abdominal muscle tone account, to a great extent, for the high incidence of constipation in pregnancy.

Smooth, gentle, normal evacuation—the desired action in pregnancy constipation management—is afforded by the "smoothage" of Metamucil.

By providing soft, plastic, water-retaining bulk, Metamucil promotes normal, easy peristaltic movement.

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counties, not to exceed a total of four, after receiving approval of the State Board of Health, to establish a full-time health department. Under this particular law, the proposition is voted on at the next general election, after a petition signed by 10 per cent of the resident freeholders is presented to the county board of commissioners. If a majority of the votes cast upon the question is favorable, the commissioners must establish a full-time health department and the county council of any county in which a full-time health department has been authorized must levy a tax, not to exceed one mill on each dollar of taxable property, for the purpose of financing the program.

The board of health in a single county unit will consist of seven members appointed by the county commissioners, three of whom must be physicians, one a dentist, one a school superintendent, and two others selected for special fitness. In case of multiple county departments, the board will be comprised of two physicians, one school superintendent, and one person selected for special fitness from each of the participating counties. The county or multiple county boards of health have been given powers similar to those of the city-county boards.

A third bill *(H. B. 254)*, introduced by Legislators from Lake County and applying specifically to their county, was passed and provides a practical solution to problems peculiar to this metropolitan area. This act differs from previous legislation pertaining to establishment of full-time health departments by cities, in that it prescribes the method of appointment and tenure of members of the board of health and specifies their duties.

A city of the second-class within a county having more than one city of this class may establish a full-time health department under this law. The Mayor is empowered to appoint a five-member bipartisan board, three of whom must be physicians. The board, whose members serve overlapping terms, has policy-making powers, power to appoint the health officer and approve professional personnel appointed by the health officer.

A section within this act prohibits the county council levying taxes for health purposes within the corporate limits of a city of the second-class maintaining its own health department.

Since 1936 the State Board of Health has had authority to co-operate with local governmental units by providing part or all of the salary of health personnel from funds made available by the federal government. A law *(H. B. 29)* enacted by the last General Assembly makes it possible, when funds are available, for the State Board of Health to deposit allotments with the county treasurer. As a result, the county will be in a position to pay salaries of local employees. This is more desirable than the past practice of the state making direct payments to local personnel.

The State Board of Health is directed by law to perform certain specific functions for the purpose of protecting the public's health. These functions would remain the responsibility of the board even though the state were completely covered by local full-time health departments. In order that the state program might be administered more efficiently and economically, five branch offices have been established. The powers granted by the basic public health law presumably provides the Board of Health with authority to establish such offices; however, to remove any question as to the legality of such action, a law *(H. B. 33)* specifically authorizes the establishment of branch offices. This same act directs the State Board of Health to make investigations of conditions in all places of employment within the state which may be responsible for the development of occupational diseases.

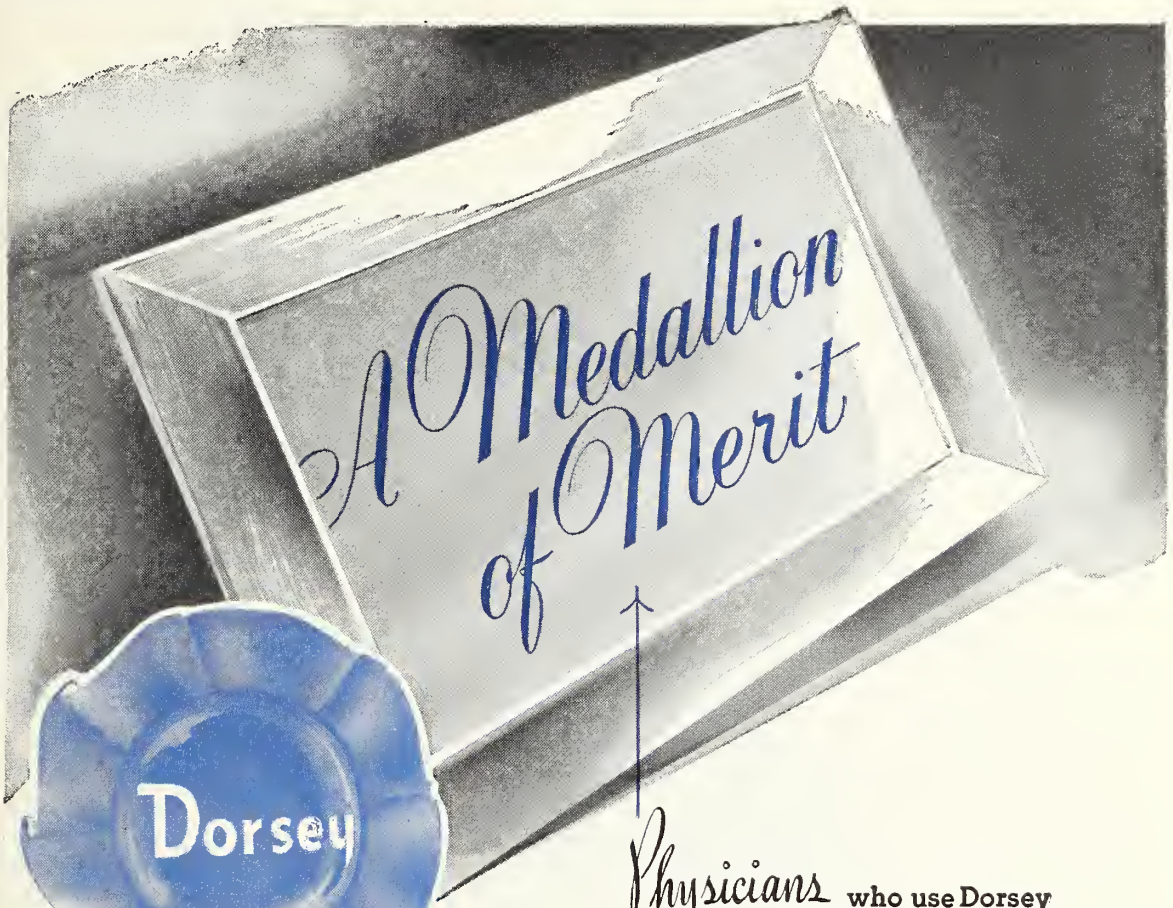
In 1945 the General Assembly directed the State Board of Health to make an inventory of all hospital and health center facilities in the state. This survey has been completed and the information gathered is now being used, with the assistance of an advisory council, in preparing a plan of hospital construction and improvement for all sections of the state. An act *(S. B. 1)* passed by the 1947 Legislature designates the State Board of Health as the agency to receive and disburse federal funds for the purpose of assisting local communities in the construction of public and non-profit hospitals and health centers.

For many years the Office of Weights and Measures has been a division of the State Board of Health. During the past several years a number of laws have been passed and others repealed involving the organization of state agencies. Somewhere along the line this particular office became a separate entity. *Senate Bill 2* abolished the Office of Weights and Measures as an independent agency and makes it an integral part of the State Board of Health.

Although the budget for the next biennium was reduced considerably from the original conservative estimate of needs, the appropriation of $718,100 for 1947-48 and $768,500 for 1948-49 represents a substantial increase over preceding years. In addition to the general budget allotment, there is a limited sum available in the Governor's contingency fund which may be drawn on for the purchase of equipment. The Legislative body also approved the construction of new housing facilities for the State Board of Health, with the understanding that the present building would be transferred to the Indiana University School of Medicine to house administrative offices and clinical laboratories.

Other bills not sponsored by the State Board of Health but which will have a definite bearing on the future of public health in Indiana were enacted into law.

Health and education authorities have always recognized that in respect to the school child's health they have many things in common; consequently, down through the years there has been a close working arrangement between the State Board of Health and the State Board of Education. A law *(H. B. 296)* recognizes and sanctions this cooperative arrangement.



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THE SIGNIFICANCE OF PUBLIC HEALTH NURSING IN INDIANA

Lucille Wall, R.N.

Indianapolis

THE week of April 20-26 is Public Health Nursing Week. This will be the third year that a definite period has been devoted to interpreting the services of the public health nurse. Citizens of each and every community have an opportunity to become acquainted with the services of the public health nurse or nurses in their locality through printed information in newspapers and various publications, radio scripts, talks, and window displays. The public health nurse is frequently so busy with the many duties that fill her day that she rarely takes the time to interpret her work to citizens other than those to whom she gives her service. If every civic-minded individual could observe the service which a public health nurse gives in one day there would be very little need for observance of a Public Health Nursing Week. Her services speak for themselves. Two commonly asked questions would be answered: "Who is the public health nurse?" and "What does she do?"

This year Public Health Nursing Week has special significance for Indiana. A new area in public health has been launched. Branch offices of the Indiana State Board of Health have been established throughout the state. There is an increased interest in the full-time county and city health units and citizens throughout the state seem to be becoming more aware of their responsibility for the health of their people. Such developments in health programs mean that an increased number of personnel will be needed. Public health nurses are considered a vital part in any health organization's personnel.

Many requests come from school boards, private agencies, county commissioners, and health departments for public health nurses. Today there are 425 public health nurses in Indiana; in order to meet the expanding programs approximately 700 are needed.

More registered graduate nurses are needed to care for the patients in hospitals, both for general duty and for private duty services; in industries to protect the health of employees; in schools of nursing to assist with teaching programs for student nurses; in universities to teach the graduate nurses who wish to become prepared for public health nursing positions, instructors in schools of nursing, or administrative positions. Stated frankly, there is a shortage of graduate nurses to fill the many vacancies in various fields of nursing and to give the service which citizens of our communities need. In order to help overcome this shortage we need additional young women to enter our schools of nursing.

There are advantages for young women in the nursing profession. First of all, the education of a student nurse tends to teach her to understand people, both mentally and physically, and to give them a service. Second, the economic security of nurses related to such factors as salaries, vacations, sick leaves, et cetera, is comparable with that provided women in any other profession. Consideration is given to security in the form of retirement plans and so forth. Nursing education is a good background for marriage and parenthood, previous surveys have shown that a large per cent of nurses become wives and parents. Only 2 per cent of the graduate nurses in the United States are males; hence, women in the nursing profession have very little competition with the opposite sex. A basic nursing education opens a field of various activities to young women. A nurse is limited only by her lack of willingness to assume responsibility and to acquire the necessary special preparation for top positions in the profession.

Directly or indirectly almost every citizen utilizes the services of a registered graduate nurse. In a like manner, every citizen can help in the observance of Public Health Nursing Week by encouraging young women in his or her community to enter the nursing profession.

ARREST TUMOR OF BONE MARROW

Two new English drugs, used in a New York hospital, have proved effective in checking multiple myeloma, a malignant tumor of the bone marrow.

No effective form of therapy was known for this highly fatal disease until these drugs—Stilbamidine and Pentamidine—demonstrated their tumor controlling and pain relieving properties.

Writing in the January 18 issue of *The Journal of the American Medical Association*, Isidore Snapper, M.D., from the Second Medical Service of the Mount Sinai Hospital, New York, reviews the treatment of 15 patients.

He states that "all these patients were suffering excruciating pains when the treatment was begun. Thirteen were immobilized in bed. All 15 improved considerably as far as the pain itself was concerned. Eleven could walk at the time of discharge from the hospital."

Dr. Snapper points out that the "treatment merely checks the disease and does not cure it."

This disease, usually associated with anemia, causes neuralgic pains. Later, painful swellings appear on the ribs and skull and spontaneous fractures may occur.

Injections into the veins of Stilbamidine proved successful in the majority of patients. However, in two who were not helped by Stilbamidine, Pentamidine was effective.


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EVANSVILLE, INDIANA, U.S.A.

Deaths

Herbert Q. White, M.D., of Grand View, died suddenly on February seventh, at his home. He was seventy-six years of age. Doctor White graduated from the University of Louisville School of Medicine, in 1893.

* * *

Daniel S. Goble, M.D., of Indianapolis, died on February sixth, at the age of seventy-eight years. Doctor Goble graduated from the Kentucky School of Medicine, in Louisville, in 1892, and had practiced medicine in Evansville before coming to Indianapolis. He was retired from active practice.

* * *

Samuel W. Hervey, M.D., of Fortville, died on January eighth, at the age of eighty-one years. Doctor Hervey was graduated from the Medical College of Indiana, in Indianapolis, in 1887, and had been a practicing physician in Fortville for the past sixty years. He was an Honorary member of the Hancock County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Sherman T. Rogers, M.D., of New Albany, died in Silvercrest, on February sixth. He was eighty-two years of age. Doctor Rogers was graduated from the Eclectic Medical College, in Cincinnati, in 1887, and has been a practicing physician in New Albany for over half a century. He had served as health officer of New Albany and Floyd County for five years. Doctor Rogers was a member of the Floyd County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

Elizabeth V. Burns, M.D., of Fort Wayne, died on February twenty-third, following an illness of several months. She was seventy-eight years of age. Doctor Burns graduated from the University of Illinois College of Medicine, in Chicago, in 1902. She was an Honorary member of the Fort Wayne (Allen County) medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Ernest M. Deputy, M.D., of Dugger, died at his home on February tenth, following an illness of four years. He was sixty-nine years of age. Doctor Deputy was a graduate of the Kentucky University Medical Department, in Louisville, in 1903, and had been a practicing physician in the vicinity of Dugger, for the past forty years. He was a member of the Sullivan County Medical Society, the Indiana State Medical Association, and the Americal Medical Association.

Louis D. Belden, M.D., of Indianapolis, died on November twenty-eighth, at the age of fifty-nine years. Doctor Belden graduated from the Johns Hopkins University School of Medicine in 1915. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Ray Henry Thomas, M.D., of South Bend, died July 30, 1946, at the age of fifty-eight years. Doctor Thomas graduated from the Indiana University School of Medicine, in Indianapolis, in 1914. He was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Monroe Shaul, M.D., of Boonville, died on February fifteenth, at the age of ninety-three. Doctor Shaul graduated from the Kentucky School of Medicine, in Louisville, in 1883. He retired from active practice approximately twelve years ago.

* * *

William P. Lomax, M.D., of Evansville, died on March twelfth, at the home of a son. He was ninety-one years of age. Doctor Lomax graduated from the Medical College of Indiana, at Indianapolis, in 1881, and had practiced medicine for approximately sixty-five years, having retired several years ago.

* * *

James W. House, M.D., of Bruceville, died on March third, following an illness of several months. Doctor House was seventy-eight years of age. He graduated from the Ohio State University College of Medicine, in Columbus, in 1908, and had practiced in Bruceville for the past twenty-eight years.

* * *

Joseph W. Horton, M.D., of Monrovia, died on March tenth, at the age of seventy-seven. Doctor Horton graduated from the Medical College of Indiana, at Indianapolis, in 1900, and for forty-seven years had practiced medicine in the community of Monrovia. He had retired several years ago, but resumed his work during World War II.

* * *

Julius H. P. Gauss, M.D., of Indianapolis, died on October thirty-first. He was seventy-four years of age. Doctor Gauss graduated from the Rush Medical College, in Chicago, in 1903, and specialized in internal medicine. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Addressed to your women patients

In its current "See Your Doctor" advertisement Parke, Davis & Company emphasizes the importance of seeking medical counsel at the time of menopause. This educational campaign, in behalf of the medical profession, appears regularly in color in LIFE and other leading magazines.



Some things you should know about the **menopause**

No. 203 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

FOR most women today the period of menopause, or "change of life," need cause little apprehension.

It is an established fact that most of the physical discomfort and mental strains of this time are *directly traceable* to the changing functions of the ovaries and other glands.

During the past few years, medical science has learned many things about the glands," and the hormones they produce. As a result, your doctor has at his command new and successful methods of controlling the symptoms of this type of glandular imbalance.

Hot flushes, headaches, nervous tension, mental depression, sudden gain in weight, and insomnia . . . your doctor can usually relieve these common menopausal symptoms.

But there are other reasons, too, why you should consult your doctor as soon as you notice any signs of the menopause.

At this time, your body undergoes many changes. It's the time when you are most likely to have a rise in blood pressure or a tendency toward gastro-intestinal disturbances.

Also, it's important to be sure that irregular menstrual periods actually indicate the onset of the menopause rather than pregnancy, or the presence of cancer or some other disease.

SEE YOUR DOCTOR. He can help you avoid many physical and mental problems during the menopause. Equally important, his supervision and understanding counsel at this time is your best security for continued good health in the years to come.

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News Notes

Dr. R. F. Harwell, who has been practicing medicine in Richmond since 1941, has gone to Los Angeles, California, to take over the practice of his late father.

Dr. John L. Emenhiser is again associated with his brother, Dr. Donald C. Emenhiser, in the practice of medicine, in New Haven.

Dr. George Westfall, who served three and one-half years in the Army, has located in the Dr. Page Building, in Goshen, for the general practice of medicine.

After five and one-half years of service in the Army, Dr. Guy A. Owsley has returned to Hartford City, where he will resume his practice in eye, ear, nose and throat.

Announcement has been made by Dr. R. M. Stover, of the opening of an office for the general practice of medicine in the Myers Building, in Winamac.

Announcement has been made that Dr. Leslie M. Baker has become associated in the practice of medicine with Dr. J. K. Jackson, in Aurora. Doctor Baker, who served for five years in the Army, was discharged as a lieutenant-colonel in February, 1946. He saw combat duty in France, Belgium, Luxembourg and Germany.

Announcement has been made of the marriage of Miss Mildred Bradshaw, of Carbon, and Dr. George V. Teter, Jr., of Fort Wayne. The wedding took place on January eighteenth, in Brazil. The couple will establish residence in Indianapolis, since Doctor Teter is interning at the Indianapolis City Hospital.

Captain Harvey D. Lovett, of Zionsville, recently returned from twenty-three months service. He entered the Medical Corps in February, 1945, and spent some time at Carlisle Barracks, at Schick General Hospital, in Clinton, Iowa, and with the 2nd Division, at Camp Swift, Texas, before going to Tokyo with the 385th Medical Dispensary. Doctor Lovett was in charge of a branch dispensary there. While in Tokyo he was situated near a leprosarium which contained 2,600 patients. There are approximately nine such leprosariums in Japan, according to Doctor Lovett, and a Japanese physician is doing revolutionary work on leprosy there. Doctor Lovett has announced the opening of an office in Whitestown for the general practice of medicine.

Dr. Lyman D. Eaton, formerly of Evansville, has announced the opening of an office for the practice of medicine and surgery in the Star Building, in Franklin.

Drs. Richard and Roger Smith have returned from military service and have become associated with their father, Dr. G. A. Smith, of New Haven, for the general practice of medicine.

Dr. F. H. Spurlock, formerly of Cloverdale, has opened an office in West Lafayette. Dr. Spurlock will specialize in internal medicine.

Dr. Meredith B. Gossard, formerly of Fairmount, has opened an office with Dr. Frederic Spencer, in the LaPlante Building, in Vincennes, for the general practice of medicine.

Dr. William J. Gerding has opened an office at 2638½ South Anthony Boulevard, in Fort Wayne, for the practice of medicine and surgery. Following his graduation from the Indiana University School of Medicine, Doctor Gerding entered the Navy and served on the west coast, in the Pacific, and with the Marines in China. Doctor Gerding has recently completed an advanced course in medicine and surgery in San Diego, California.

Floyd T. Romberger, Jr., M.D., has opened an office for the practice of obstetrics and gynecology, at 3440 North Meridian Street, in Indianapolis. Doctor Romberger was separated from the service in 1945, after having spent five years of active duty with the Army, two and one-half years of which were spent on the Ledo Road in India and Burma. He has been serving a residency in obstetrics and gynecology at the Coleman Hospital, in Indianapolis, since his discharge.

Captain M. Richard Harding, of Indianapolis, recently discharged from service, is now associated with his father, Dr. Myron S. Harding, in the practice of ophthalmology, at 308 Hume Mansur Building, in Indianapolis. Captain Harding entered the service in June, 1945, and spent two months at Carlisle Barracks; then he was transferred to Fort Bragg, North Carolina, where he remained during his entire period of service. For approximately one year Doctor Harding served as ophthalmologist at the Armed Forces Induction Station, the separation center, and the regular Army screening section. He served as chief of the eye section at the Regional Hospital at Fort Bragg for three months.



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"ANDROGENS IN FEMALE" SUBJECT OF NEW 1947 SCHERING AWARD COMPETITION

"The Clinical Use of Androgens in The Female" has been selected as the subject for the 1947 "Schering Award" competition among medical students in the United States and Canada. As in previous years, cash prizes of $500, $300, and $200 will be given for the best manuscripts received on this subject. Three judges prominent in endocrinology will select the winning entries. Dr. Norman L. Heminway, head of the Schering Medical Service Department, is chairman of the Schering Award Committee and in charge of the competition.

The "Schering Awards" are offered annually in competition to stimulate the acquisition of further knowledge of endocrinology by medical students.

The National Society for the Prevention of Blindness announces that papers submitted for the glaucoma prize of $500 offered in 1944 did not conform to the criteria set up by the ophthalmological committee selected to award the prize. Therefore, the prize is again offered for the most valuable original paper adding to existing knowledge about the diagnosis of early glaucoma or the medical treatment of non-congestive glaucoma. The criteria may be secured by writing to the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y. Papers may be presented by any practicing ophthalmologist of the Western Hemisphere and may be written in English, French, German, Italian, Spanish or Portuguese. Those written in any of the last four languages should be accompanied by a summary in English. Closing date for receipt of papers is December, 1947.

The Annual Meeting of the Indiana Trudeau Society, which is the medical section of the Indiana Tuberculosis Association, will be held May 7 in the Hotel Lincoln, Indianapolis. Several outstanding authorities on tuberculosis work have been engaged to speak during the sessions. These will include Dr. Herman E. Hilleboe, Assistant Surgeon General, U.S.P.H.S., Washington, D.C., Dr. Michael L. Furcolow, U.S.P.H.S., Kansas City, Kans., Dr. Carl H. Pfuetze of Cannon Falls, Minn., and Dr. Harold C. Ochsner, Indianapolis.

ANNUAL MEETING AMERICAN COLLEGE OF CHEST PHYSICIANS

The Thirteenth Annual Meeting of the American College of Chest Physicians is scheduled to be held at the Ambassador Hotel, Atlantic City, New Jersey, June 5 to 8. An interesting scientific program has been planned for this meeting. Prominent speakers from other countries will present papers.

The oral and written examinations for Fellowship will be held on the first day of the meeting, June 5. Applicants for Fellowship in the College who plan to take these examinations should communicate at once with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation for new Fellows and Life Members of the College will be held on Sunday, June 8. At this time certificates will be awarded to Fellows and Life Members admitted since June 1946.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

March 9, 1947.

Roll call showed the following present: Cleon A. Nafe, M.D.; C. H. McCaskey, M.D.; F. T. Romberger, M.D.; Alfred Ellison, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guest: Norman M. Beatty, M.D., co-chairman, Committee on Public Policy and Legislation.

On motion of Dr. Ellison, seconded by Dr. Nafe, Dr. McCaskey was elected chairman of the committee for 1947.

Membership Report

Number of members Feb. 28, 1947	3,073*
Number of members Feb. 28, 1946	2,761
Gain over last year	312

* Includes 90 in military service (gratis), 162 honorary members.

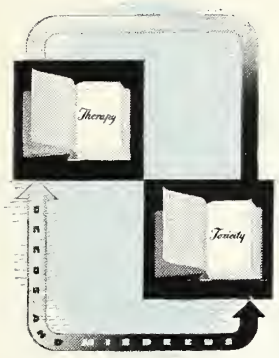
Legislative Matters

Local

Dr. Beatty gave a report on the committee's activities during the 1947 General Assembly.

National

S. 140, Fulbright-Taft bill, which would create a Department of Health, Education, and Security in the Federal Government. It is the feeling of the Executive Committee that the state medical association should be guided by the action of the A.M.A. House of Delegates and Board of Trustees in its position for or against this measure. The executive secretary was directed to contact the secretary of the Bureau of Legal Medicine and Legislation to learn the American Medical Association's attitude on this bill.



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1947 Annual Session, French Lick, October 28, 29, 30, 1947

Technical exhibit. Layout for the technical exhibit was approved on motion of Drs. Romberger and Nafe.

Organization Matters

American Public Health Association. The secretary was instructed to take out a membership in the American Public Health Association at a cost of $5.00 per year, on motion of Drs. Nafe and Ellison.

Indiana State Conference on Social Work. Continuation of membership in the Indiana State Conference on Social Work to the extent of $10.00 per year was approved on motion of Drs. Ellison and Nafe.

Conference of Presidents and Other Officers of State Medical Associations. On motion of Drs. Ellison and Nafe an invitation to become a member of the Conference of Presidents for 1947 at a cost of $50.00 was rejected.

State Nutrition Council. Membership on the State Nutrition Council was approved. The president is to appoint one member of the state medical association to this Council.

Scholarship Committee. Copy of the Declaration of Trust adopted by the Scholarship Committee at its meeting on March 2, 1947, is to be sent to each member of the Executive Committee.

Woman's Auxiliary Expense. On motion of Drs. Ellison and Nafe, request of the chairman of the Finance Committee of the Woman's Auxiliary for $100.00, to defray Auxiliary annual state convention expenses, was approved, with the recommendation that this amount be allowed by the Budget Committee.

Statements of receipts and expenditures for January and February for the Association committees and THE JOURNAL were approved.

Veterans Affairs

Dr. Charles F. Thompson and Dr. Dudley Pfaff appeared before the committee and presented an amendment to the original agreement between the Veterans Administration and the Indiana State Medical Association which was to the effect that "the Indiana State Medical Association warrants that the rates charged in the attached schedule of fees are not in excess of the rates charged other persons who are not Veterans Administration beneficiaries for the same service." Drs. Thompson, Garner and Giordano, who had signed the original contract, were instructed to sign the amended agreement, on motion of Drs. Romberger and Ellison.

The attorney for the state medical association was instructed to draft a procedure for the committee to use in determining whether or not a physician should be disqualified from rendering service to veterans under the existing agreement. This policy was approved by the committee on motion of Drs. Nafe and Ellison.

The Journal

Report on advertising:

Additions	$697.03
Reductions	745.84
Decrease in January and February, 1947	$ 48.81

There being no further business, the meeting was adjourned.

The next meeting of the committee is to be held at 6:30 p. m., Saturday, April 12, 1947, at the Columbia Club.

BUREAU OF PUBLICITY

February 3, 1947

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of February 17, 1947—"Body Needs Calcium."

Week of February 24, 1947—"The Lingering Cough."

Week of March 3, 1947—"Migraine Headache."

A letter from the editor of *The Ligonier Banner* expressing his thanks for "Hints on Health" was read.

The secretary reported that the booklets, "Check and Double Check on Sickness Insurance," would be mailed to the debate coaches of more than a hundred Indiana high schools within a few days.

Copy for a booklet entitled, "Why Indiana Doesn't Need a Chiropractic Board," being issued by the Legislative Committee, was read and approved.

February 24, 1947

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

Copy for the following "Hints on Health" columns was approved:

Week of March 10, 1947—"Stomach Ulcer."

Week of March 17, 1947—"Eat Adequate Breakfast."

An advertisement placed in Oklahoma newspapers by the Oklahoma Medical Association was discussed.

A series of medical recordings, "The Public Comes First," for use on WFBM, Indianapolis, was approved.

A 1947 budget request of $1,360, for submission to the Budget Committee, was voted.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

WABASH COUNTY MEDICAL SOCIETY
President, George W. Seward, North Manchester,
Vice-President, James G. Kidd, Roann,
Secretary-Treasurer, J. T. Stoops, Wabash.



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Boone County Medical Society members held a dinner meeting at the Witham Memorial Hospital, in Lebanon, on February fourth. The thirteen members present heard Dr. Bennett Kraft, of Indianapolis, speak on "Allergy."

Elkhart County Medical Society members held a dinner meeting at the Hotel Elkhart, in Elkhart, on February sixth. Sixty members attended the meeting and heard Dr. David A. Boyd, of Indianapolis, discuss "Psychosomatic Medicine."

At a dinner meeting at the Hotel Elkhart, in Elkhart, on March sixth, Dr. Samuel W. Banks, of Chicago, presented a paper, his subject being "Orthopedic and Fracture Problems in General Practice." Sixty members attended the meeting.

Fort Wayne (Allen County) Medical Society members met in Fort Wayne, on February eighteenth. The guest speaker of the evening was Dr. Leroy E. Burney, of Indianapolis, whose subject was "Organization and Function of the Indiana State Board of Health." Forty members attended the meeting.

Floyd County Medical Society members met for a dinner meeting at the New Albany Country Club, in New Albany, on February fourteenth. Dr. A. P. Hauss, of New Albany, discussed pending bills in the Legislature. Nineteen members were in attendance.

Fayette-Franklin County Medical Society members met on February eleventh, at the McFarlan Hotel, in Connersville. The guest speakers were Dr. Ralph U. Leser, of Indianapolis, whose subject was "The Use of Penicillin, Sulfonamides and Streptomycin," and Dr. Daniel C. Barrett, of Columbus, whose subject was "Ringworm of the Scalp." Seventeen members attended the meeting.

Grant County Medical Society members held a dinner meeting on February twenty-seventh, in Marion. Twenty-five members attended the meeting, which was addressed by Dr. Carl P. Huber, of Indianapolis, whose subject was "Cesarean Sections."

Greene County Medical Society members met at the Freeman Greene County Hospital in Linton, on February thirteenth, for a dinner and business meeting. The guest speaker was Dr. Carl M. Porter, of Jasonville, who presented a paper on "Rheumatism." Fourteen members were in attendance.

Indianapolis (Marion County) Medical Society members held a meeting at the White Cross Service Center, at the Methodist Hospital, in Indianapolis, on January fourteenth. Dr. Ernest Rupel, of Indianapolis, spoke on "Bladder Trouble in Women," and Dr. C. H. McCaskey, of Indianapolis, spoke on "Carcinoma of the Larynx."

A second meeting was held on January twenty-first. Dr. Harold Ochsner, of Indianapolis, discussed "Radiological Chest Survey in a General Hospital," and Dr. W. D. Gatch, of Indianapolis, discussed "Derangements of the Peripheral Circulation."

The members met on February eleventh, in the Nurses' Home Auditorium, St. Vincent's Hospital, in Indianapolis. The guest speakers were Dr. Walter P. Moenning, of Indianapolis, whose subject was "Value of Friedman Studies in Operative Gynecology," and Dr. Karl R. Ruddell, of Indianapolis, whose subject was "Surgery in Lesions of the Descending Colon."

Another meeting was held on February eighteenth. Dr. C. G. Weigand, of Indianapolis, spoke on "Protein Therapy," and Dr. Thomas B. Noble, Jr., of Indianapolis, spoke on "Return to Sanity."

Jay County Medical Society members held a dinner meeting at the Portland Country Club, in Portland, on February seventh. Fourteen members attended the meeting.

Marshall County Medical Society members met on February fifth, in Plymouth. The eighteen members present heard Dr. Frederic G. Perry, of Plymouth, discuss "Some Common Skin Diseases, Their Diagnosis and Treatment."

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, in Clinton, on February nineteenth, for a dinner meeting. The guest speakers for this meeting were Dr. Earl W. Mericle, of Indianapolis, whose subject was "Recent Advances in Psychiatry," and Dr. Paul Merrell, of Indianapolis, whose subject was "Acute Head Injuries." The meeting was attended by fourteen members.

Putnam County Medical Society members were dinner guests of Dr. W. R. Hutcheson, of Greencastle, on February thirteenth. Dr. Paul Merrell, of Indianapolis, was the guest speaker, and his subject was "Head Injuries." Fourteen members and their wives were present.

Wayne-Union County Medical Society members met at the Reid Memorial Hospital, in Richmond, on February thirteenth. The guest speaker for this meeting was Dr. Philip E. Piker, of Cincinnati, whose subject was "Psychiatric Aspects of General Practice." The meeting was attended by twenty-four members.

Whitley County Medical Society members held a meeting in Columbia City, on February eleventh. Dr. Samuel R. Mercer, of Fort Wayne, gave a talk, illustrated with kodachrome slides, on "Skin Carcinoma." Ten members attended the meeting.

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Specialists	Administrators	Out-patient
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Vanderburgh County Medical Society members held a dinner meeting at Hotel McCurdy, in Evansville, on February eleventh. The speakers were Dr. Charles F. Thompson, of Indianapolis, who discussed "Veteran's Medical Care"; Dr. W. U. Kennedy, of New Castle, who discussed "The Doctor's Plan"; and Mr. Guy W. Spring, of Indianapolis, who discussed "Blue Cross Insurance." The sixty-four members present also discussed medical aid to Social Agency clinics in Evansville.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Recording Secretary—Mrs. J. L. Allen, Greenfield.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. O. H. Bakemeier, Indianapolis.

"THE THIRD ANNUAL MEETING OF THE HOUSE OF DELEGATES

"According to Article V, Section 2, each county should be represented by its president or her alternate, and by a delegate for every twenty-five members or fraction thereof.

"Because our national president, Mrs. Jesse D. Hamer, of Phoenix, Arizona, will meet with us, there will be a reception in her honor preceding the dinner at 6:00 P. M. Delegates are invited to attend the dinner and reception. Every county president please send reservations to Mrs. Gastineau for the dinner at the Indianapolis Athletic Club, April 22, and the luncheon, April 23, Columbia Club, for herself, president-elect, and delegates, not later than April 15. Board members must also send in their reservations. The members of the Board will meet immediately after dinner.

"As accommodations are still difficult to obtain, please make your hotel reservations early. Please specify Auxiliary membership when writing for reservations.

"If you cannot come to the meeting, or secure an alternate, be sure to mail your report to me. I will wish to include your work in my report to the National Auxiliary, and all the counties are anxious to hear what the others are doing. In addition, county presidents please include names of any members who will be going to the A.M.A. Convention in Atlantic City in June, who are willing to attend as delegates or alternates, and also, the names of any deceased members of your Auxiliary.

"It is my sincere hope you will give this meeting the same enthusiastic support you gave the fall meeting. Looking forward to meeting with you soon, I remain

"Very sincerely yours,

"MRS. SAMUEL J. PETRONELLA,
"President."

Bulletin Number Two

A few more months and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, New Jersey, for their Annual Convention—June 9-13.

Have you made your reservations? If not, send your requests **at once** to Dr. Robert A. Bradley, Chairman, Sub-commitee on Hotels, 16 Central Pier, Atlantic City, New Jersey.

Delaware-Blackford County

Mrs. M. G. Schulhof, of Muncie, was hostess to the Auxiliary for a six o'clock carry-in dinner and white elephant sale in February.

Floyd County

The Floyd County Auxiliary held its luncheon meeting in the New Albany Country Club on Friday, February fourteenth, at which time Dr. A. P. Hauss, of New Albany, talked on "Legislation and Medical Economics."

The Auxiliary was entertained at a luncheon on Friday, March seventh, by the president, Mrs. A. E. Stinson.

Lake County

The Lake County Auxiliary is very active and is accomplishing many worth-while projects which will be reported at the House of Delegates meeting in April and published in a later edition of THE JOURNAL. The Auxiliary is divided into three branches: Gary; the south branch; Hammond and East Chicago; and each branch has its own projects. Mrs. S. J. Petronella, our state president, is a member of the East Chicago branch.

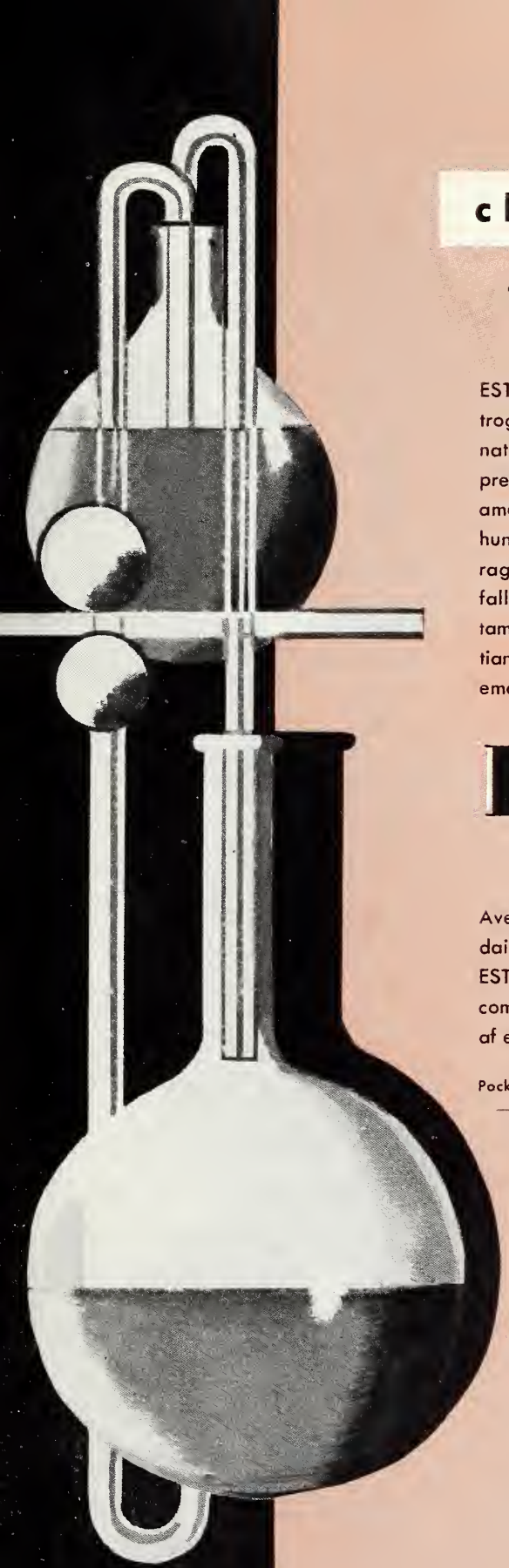
Marion County

The Marion County Auxiliary has had two meetings since the last JOURNAL went to press. The first meeting was a Legislative meeting on February twenty-first, with a luncheon at the Lincoln Hotel, followed by a visit to the Indiana State Assembly, with Mr. Ray E. Smith, executive secretary to the Indiana State Medical Association, as guide.

The second meeting was the Public Relations Guest meeting and tea, held in the auditorium of the Wm. H. Block Co., on Monday, March third. Mr. Paul Bourscheidt, executive director of the Central Illinois Hospital Association, Peoria, Illinois, was the speaker, and used as his subject, "Shall it be Uncle Sam, M. D.?"

Marshall County

On March fourth, Mrs. Donald Reed, of Culver, was hostess to the Marshall and Fulton County Auxiliaries at a luncheon given in honor of the state president, Mrs. S. J. Petronella, of East Chicago, at the Maxinkuckee Inn. Following the luncheon, the ladies went to Mrs. Reed's home where Mrs. Petronella gave a very concise and enlightening talk concerning socialized medicine. Mrs. C. R. Graham, president of the Marshall County Auxiliary, presided.



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1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

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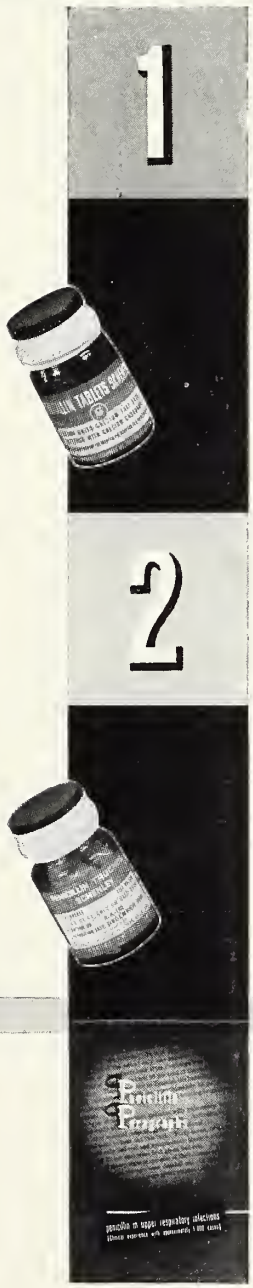
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Cass	Russell Rollins, Royal Center	Donald K. Winter, Logansport
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Crawford	N. E. Gobbel, English	H. H. Deen, Leavenworth
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Dearborn-Ohio	C. N. Manley, Rising Sun	J. C. Elliott, Guilford
Decatur	I. M. Sanders, Greensburg (46)	Robert Acher, Greensburg
DeKalb	Harry M. Covell, Auburn	P. P. Reynolds, Garrett
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Dubois	G. A. Held, Jasper	F. P. Williams, Huntingburg
Elkhart	R. A. Fleetwood, Nappanee	O. E. Wilson, Elkhart
Fayette-Franklin	I. E. Booher, Connersville	R. H. Elliott, Connersville
Floyd	Parvin M. Davis, New Albany	John M. Paris, New Albany
Fountain-Warren	Lee J. Maris, Attica	John E. Fisher, Attica
Fulton	C. L. Herrick, Akron	Howard H. Rowe, Rochester
Gibson	R. S. McElroy, Princeton	H. F. Carpentier, Princeton
Grant	Russell J. Baskett, Jonesboro (46)	R. W. Lavengood, Marion (46)
Greene	Wm. F. Craft, Linton	George E. Moses, Worthington
Hamilton	James W. Griffith, Sheridan	Robert Harris, Noblesville
Hancock	Robert O. Scott, Charlottesville	J. L. Allen, Greenfield
Harrison	E. W. Murphy, Lanesville	W. E. Amy, Corydon
Hendricks	W. C. Stafford, Plainfield	Ernest H. Price, Danville
Henry	Chester A. Marsh, Hagerstown	R. D. Spindler, New Castle
Howard	Jesse S. Spangler, Kokomo	George Jewell, Kokomo
Huntington	J. R. Ware, Huntington	G. M. Nie, Huntington
Jackson	W. H. Shortridge, Seymour	G. H. Kamman, Seymour
Jasper-Newton	Richard Schantz, Remington	W. G. Pippinger, Brook
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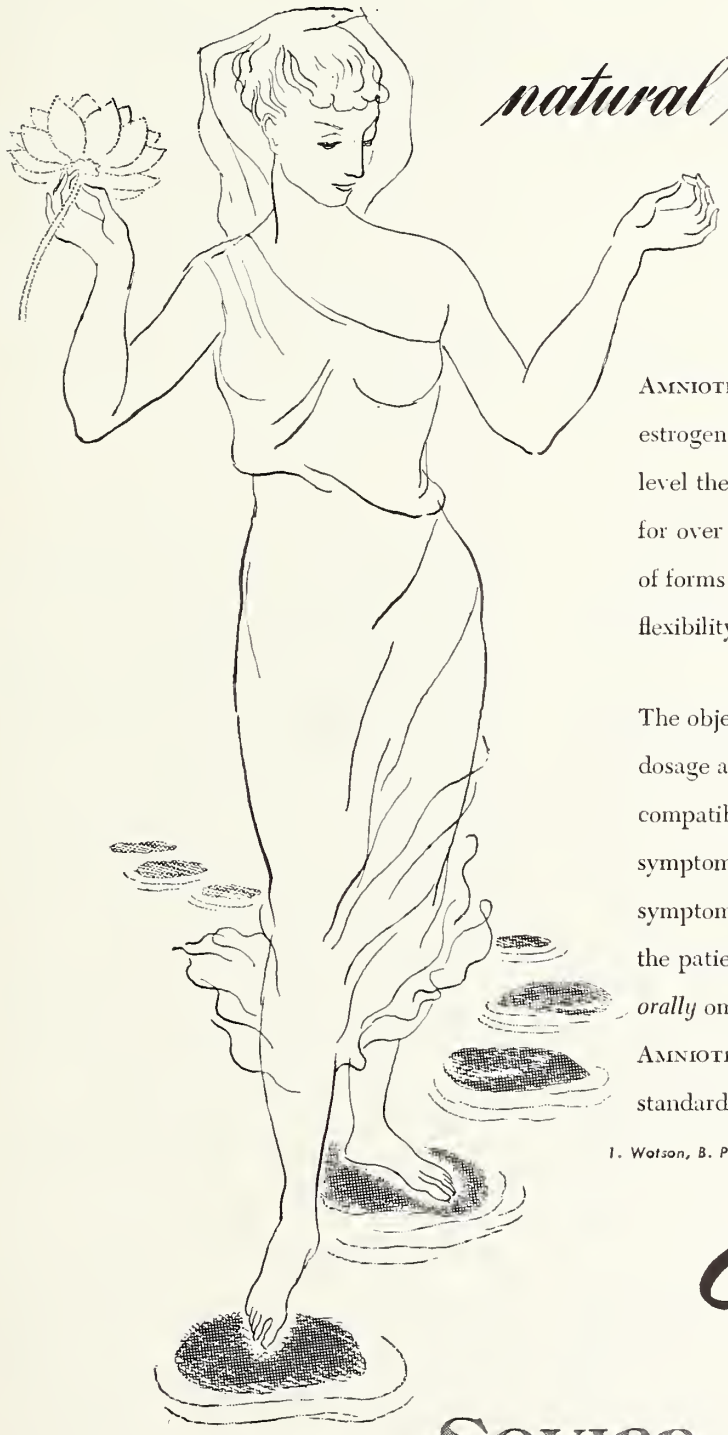
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1. Watson, B. P.: J. Clin. Endocrinology 4:571 (Dec.) 1944.

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AN OUTLINE FOR THE STUDY OF STRABISMUS CASES*

MARY ALICE NORRIS, M.D.

INDIANAPOLIS

AS THE late Dr. James W. White often said, in all branches of medicine a careful work-up and accurate diagnosis are essential for consistently good therapeutic results; strabismus cases are no exception to this rule. While the actual technique of muscle surgery is not difficult the knowledge of whether or not to operate and just which muscles to attack is harder to attain. In order to analyze fully a given case certain essential features must be noted. Accordingly, an outline of the steps which have been found helpful in these studies is presented herewith.

The aims of all strabismus therapy should be threefold: namely, good vision in each eye, parallel axes of the two eyes, and fusion. In some cases it is admitted that only the second point, which is really an anatomic or cosmetic result, is possible. In many, however, if the proper approach is made, a physiologic or functional success will be obtained.

For a working knowledge of the case the physician must observe the function of the individual muscles, the function of groups of muscles as they work together, the near point of convergence, the refractive error, and the presence or absence of fusion at the angle of squint. From this information the indication for the use of eye glasses, orthoptics, surgery, or any combination of the three may be weighed.

A routine for the average strabismus case should include the following points of information:

1. History.
2. Record of visual acuity with and without correction.
3. Refraction.
4. Fundus examination.
5. Motility with monocular and binocular fixation.
6. Screen test for distance, near, and in the six cardinal fields.
7. Convergence near point.
8. Study of the fusional powers at the angle of squint.

HISTORY

This should include the age of onset and duration of the deviation, events just prior to the onset, and the variability or constancy of the apparent degree of tropia. If amblyopia is present, the age of onset and duration have a prognostic significance relative to the restoration of vision. The older the child at the beginning of the turning, and the shorter the duration before occlusion is started, the more hopeful one may be for an improvement of acuity. In a paralytic strabismus the story of the events just preceding the onset may be very important. In many cases family history may reveal some interesting facts regarding the heredity.

VISUAL ACUITY

The visual acuity should be recorded without correction and, after refraction, with correction in place.

REFRACTIVE ERROR

The study of the refractive error in convergent squints is usually delayed until the second visit in order that maximum cycloplegic effect may be obtained by the use of atropine. Homatropine,

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

paredrine, and sometimes atropine, may be used satisfactorily as an office procedure in older children regardless of the type of deviation, and in all divergent strabismus cases. In some the cause of the deviation will be found in anisometropia or in high hyperopia. The position of the eyes in a convergent strabismus under cycloplegia may or may not give a clue as to the efficacy of glasses as a therapeutic measure. As a rule, eyes which are straight under drops will also be straight with glasses. However, the author several times has seen children whose degree of esotropia was marked under cycloplegia straighten with glasses. This, no doubt, represented an incomplete paralysis of accommodation in spite of the routine nine instillations of atropine at home over a period of three days.

Fundus Examination

The usefulness of the fundus examination is obvious. No one would care to waste time in occluding a poorly seeing eye or in conducting an examination for fusion if a macular lesion or optic nerve pathology were present.

Motility

While the history is being taken and other preliminaries completed the examiner should be observing the patient's posture for any head-tilting or turning, either of which may suggest the presence of a paralytic muscle. The ability of each eye to fix is noted and any preference for one certain eye is recorded. The motility or excursion test is performed, both with monocular and binocular fixation. In this a small test object, such as a tiny light or white pin, is carried into the extremes of temporal and nasal rotation and into the four quadrants. Any apparent weakness, overshoot, or nystagmoid motion is noted and recorded. While binocular fixation is being used, the choice of the fixating eye is detected in the various fields, the significance of which has been discussed by Doctor White.[1] When there is a marked preference, usually the nonfixing eye is the choice for surgery if the vertical muscles are to be subjected to operation. An eye that may seem to lag in a given field when binocular fixation is used may show no real weakness in that direction if the other eye is covered and it becomes, of necessity, the fixing eye in said field of action.

Another helpful procedure at this stage is the screen comitance test. In this a card is so held that both eyes may be observed though only one perceives the test object. This is useful in the observation of lagging muscles and secondary contractures.

Screen Test

The accurate measurement of the deviation is most important to diagnosis, especially if surgery is contemplated. One can, of course, make a hasty calculation by the Hirschberg test from the light reflexes on the cornea. The degree may also be measured on the perimeter—this, too, by observance of light reflexes on the pupils. These tests measure only the eyes in the primary position and are not satisfactory. In order to measure the functional ability of the muscles, the screen test using prisms, so long taught by Drs. Duane, White[2] and Brown, is used. This simple test is easy to use even on young children. It is an objective test and is not time-consuming after practice. Many small children as young as the age of three respond very well. Only the ability to fix with each eye is necessary. If fixation is not present, then one of the corneal reflex tests must be used as a poor substitute.

Readings are made for distance and near with and without correction and also in the six cardinal fields without correction. The patient fixes on a small light in these various positions and prisms are added until no motion is seen when the screen is moved from one eye to the other. By this means the action of the individual muscle, as compared to its yoke muscle, may be studied. Such studies prove the presence of vertical anomalies in surprising frequency. For example, the most common vertical is a weakness of a superior rectus with secondary deviation of its yoke, the inferior oblique of the other eye. If the deviation has long been present, there may also be a secondary contracture of the antagonist, the inferior rectus of the same side. The action of the groups of muscles is analyzed by comparing the readings of the deviations for distance and near together with the next diagnostic point, the near point of convergence. If the deviation is an esotropia which is greater for distance than near, and the near point of convergence is seventy or more, the patient has a divergence insufficiency. If, on the other hand, the degree of esotropia is greater for near than distance and the n.p.c. is low, the diagnosis is that of convergence excess. Certainly the therapeutic measures should be different for the two. Similarly an exotropia which is greater for distance than near, associated with a good convergence near point, is a divergence excess, while the exotropia which is greater for near with a poor n.p.c. is a convergence insufficiency. Some cases may represent a combination of the two.

Convergence Near Point

The measurement of the near point of convergence in a squint is a relative one and is taken at the point at which the deviating eye gives up the attempt to converge and wanders out. The measurement may be taken from the anterior focal point of the eye, in which case it is known as near point of convergence, or if twenty-five is added it is known as PcB. The normal PcB. is forty-five

1. White, J. W. The Choice of the Fixating Eye in Paralytic and Non-Paralytic Strabismus. *Tr. Am. Ophth. Soc.*, 1943.

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to ninety for the average child. However, some with narrow interpupillary distances normally show a lower reading.

Fusion

If the deviating eye can be straightened with glasses, the ability to fuse may be tested satisfactorily on a stereoscope. However, if the deviation remains, tests for possible fusion may be conducted at the angle of squint on some type of amblyoscope or, if the angle is not too great, by means of split cards on the stereoscope.

When the data gathered from the above tests is assembled, the diagnosis and method of treatment can be worked out intelligently. While the writer admits that many a case has been cosmetically straightened with no more than a diagnosis of esotropia or exotropia of so many degrees, it is her firm conviction that the percentage of successes, and especially the percentage of physiological successes, may be definitely increased by more careful and complete analysis of the case. And to the physician a physiological success definitely is a much greater source of satisfaction than a cosmetic result.

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Discussion

Bernard J. Larkin, M.D. (Indianapolis): Dr. Norris' timely and instructive presentation was greatly appreciated. If the "Outline for the Study of Strabismus Cases" was followed by members of the Section we would have a more practical and uniform procedure which would enable us to attain more easily the proper diagnosis and the logical treatment based on such a diagnosis.

The outline as given in the paper is about the same as our office routine: history, visual acuity, the screen test for distance and near, and the associated parallel movements; whenever there is any doubt about a muscle, I have the patient cover the other eye and note the results.

For a rapid estimate of the amount of strabismus, the Hirschberg test is used, especially in small children, those with amblyopia, and those who suppress. This is a very simple test, made as follows: The observer attracts the patient's attention with a small electric light held about a foot in front of the eyes. The position of the light image on the cornea of the squinting eye is carefully noted. If it falls on the temporal edge of the pupil, the squint is about fifteen degrees; if it falls midway between the pupillary margin and the limbus, the deviation is about thirty degrees; if it falls on the sclerocorneal margin, the deviation is about forty-five degrees. This is a practical and fairly accurate method, but is for the primary position only. Recently there was an ex-G.I. in the office who stated that he had some pieces of shrapnel at the base of his spine. Since this injury he has been having eye discomfort. In the routine check of his ocular muscles it was found that he had an esophoria of eight degrees in the primary position. Without this information being passed on, the young lady in my office was asked to use the Hirschberg test on the patient. She reported that the light reflex on the non-fixing eye was about half-way between the center of the cornea and the temporal pupillary margin, which is approximately 7½° or 8°.

The screen test in the six cardinal positions will probably slow you at first but with the Hirschberg test to give you an approximate lead as to the amount, you can select a prism corresponding to that amount, place it base out for an esotropia or base in for an exotropia, before one eye, and then either increase or decrease the amount as you find necessary. After the deviation at the primary position is found, for distance and near, the test object is held at a distance of 33 cm. in each of the cardinal positions, and the same procedure followed. You no doubt think this is time-consuming, but only recently Doctor Norris stated that with a co-operative patient she could get the deviation in the primary position for distance and near, and in the six cardinal positions, in five minutes. I have heard Doctor White say that it could be done in three minutes. With patience and practice you, too, can master it. The essayist states that vertical deviations are found with surprising frequency. This is certainly true and you will also find that when you have corrected the vertical deviation, the lateral decreases.

The screen comitance test, in which a card is held in such a way that first one eye and then the fellow eye fixes the object in the six cardinal positions, but both eyes can be observed by the examiner, is a very important one.

The near point of convergence: with either exotropia or esotropia, the eye turns out at that point when the deviating eye gives up its attempt to converge. The amount is noted in the number of millimeters. The measurement is taken from the anterior focal point of the eye, 13.5 mm. in front of the cornea, but as the center of rotation is 11.5 mm. behind the cornea, these two distances make up the additional 25 mm. which must be added to the amount of millimeters at which the PcB. is recorded.

Usually some attempt is made to check the child's fusion or suppression on the stereoscope, or some type of amblyoscope. The fusion test is attempted at the angle of squint.

The problem is then discussed with the parents of the child, emphasizing the important part they play in the success of the treatment. A prescription for atropine sulphate 1 per cent, either solution or ointment, is given, to be used in each eye three times daily, after meals, for three days prior to refraction. The parents are told that if they use the solution to be sure that the puncta are held at the time of the instillations. Reactions occur less frequently when ointment is used. Doctor White stated that if you test the muscles under cycloplegia you will know the results you may expect from your correcting glasses.

Of course, the fundus examination can be made at any time.

In the first sentence of her paper Doctor Norris states "While the actual technique of muscle surgery is not difficult, the knowledge of whether or not to operate and just which muscle to attack is harder to attain." This is what we emphasize in teaching the residents. The following is a good example: In August, 1945, a young college student, aged eighteen, presented herself for examination, with the statement that she had had two muscle operations on her left eye but that the eye still crossed and she wished advice as to possible further surgery. After two operations the palpebral fissure was smaller on the left side than the right. There was a pseudo-ptosis. The eye was definitely lower than the right. There was a difference in the level of the two eyes, and involvement of the superior rectus. If this diagnosis had been made at the first examination and the proper surgery performed, the girl would have avoided years of embarrassment.

A REPORT ON INDUSTRIAL OPHTHALMOLOGY IN EVANSVILLE, INDIANA

William M. Cockrum, M.D.

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EVANSVILLE

THIS is a report on the Evansville Shipyard and other industrial plants in the city of Evansville, Indiana. The shipyard is specified on account of the high incidence of eye injuries during its operation. It is important to bear in mind that due to wartime emergency little attempt was made to limit the occurrence of eye injuries. The laborers were for the most part "green." They were inexperienced in working around industrial hazards and had little or no respect for safety programs. The management elected, because of the labor shortage, not to exert too much pressure in making the employees "safety conscious."

The shipyard was an open yard; that is, the ships were constructed outside of buildings. The yard was not in existence in 1940 and was out of existence in 1946. It was hurriedly constructed for the purpose of assembling ships rapidly and not much emphasis was placed on safety measures.

The shipyard gave each applicant a pre-employment physical examination at the employment office and records were available to us. The eye examination consisted of ascertaining visual acuity at twenty feet, and color perception. Visual acuity of 20/30 was acceptable for general employment; that is, the employee must have 20/30 vision in each eye. If an employee had vision of 20/40 in one or both eyes he then was called a "handicapped employee"; he was employed for a specific job and could not be sent to another department or used for other than specified work without the consent of the department head. There was no waiver on visual impairment signed by the employee, and an employee with vision of 20/30 in one eye only was employed with handicap.

The Safety Department furnished, and requested that the employees wear, the type of safety devices then generally accepted in this type of employment. They were available in adequate numbers and without cost. Some workers, at their own expense, obtained specially ground safety glasses and wore goggles and shields that were not available through the company. Again may we emphasize that many of the workers did not wear the safety devices even though they were available.

When an employee was injured the usual routine was to obtain a first-aid pass from the foreman and then report to the first-aid station. However, frequently the foreman was not available to issue a pass. These passes were not required by the first-aid station but were issued to give the impression that the employee was being observed in his time off. At the first-aid station the history was obtained by the receptionist. She noted the time, place, and what the employee was doing at the time of injury. The employee was then turned over to a registered nurse. Visual acuity was not taken. The nurse removed all foreign bodies that did not require use of a sharp instrument. All cases that the nurse could not handle were then turned over to the surgeon-in-chief, who was not an oculist. If he could not handle the case it was then turned over to one of the oculists in this community. The injured employee was sent to the office of the oculist and waited his turn and then was sent back to the shipyard or dismissed to go home. The medical cost embraced the time lost traveling to and from the doctor's office, the doctor's fee, the transportation fee, price of medicines, and time off from work.

Our office was approached in the spring of 1944 by shipyard officials. We were told that the cost of eye injuries had mounted to about $6,500 per month, and that eye injuries represented about 60 per cent of the total number of injuries of all types in the yard. The employment peak at this time was about 18,000. During our conference we concluded that there were several reasons for the high cost of eye care. The chief reason was the high in-

cidence of ocular injuries. This we were told would have to be disregarded for the time being. The management was interested in reducing the time lost per each individual injury and in reducing the number of visits per injury in the doctor's office. At that time the procedure was for the dispensary secretary to call oculists' offices until she found one who was in and could see the patient. This system entailed considerable loss of man-hour time, as well as additional expense to the employer, which proved to be quite unsatisfactory.

We agreed in April of 1944 to take this work on a contract basis. We were given full charge of eye cases, both from the standjoint of care by us and instructional care by nurses in the dispensary. We decided to visit the yard each morning at 8:30 A.M., thus seeing the injured cases going off "graveyard" shifts and the injured cases coming on for day shifts. Other cases that occurred during the day were to be sent to the office, treated by the nurses, or held over until our next day's visit. For the one month prior to our contract, March 17, 1944, to April 17, 1944, 382 patients were sent to individual oculists in the above described manner. For the first month after the start of our contract 385 patients were seen by us in the shipyard dispensary and in our office. Seventy-five of these were seen in the office, either due to the time of injury or to inadequate facilities for their particular care in the dispensary. This left 310 patients seen in the shipyard office on which no clerical work had to be done. The patients were not away from their work over thirty minutes and the patient usually was seen more than once. It was estimated by shipyard officials that at least $1,500 per month was immediately saved. Chart Number I shows that there was a decrease of nearly $1,400 on doctors' bills alone that were paid in the last half of 1944. There was also a decrease in amount of compensation paid.

At the time this office signed the contract on this work there was rather a lax system of survey and inspection done by the first-aid station in cases of eye injury. One of the first things that was done was to instruct the nurses in the manner of locating and recording the position of foreign bodies, using the familiar clock-dial system; use of fluorescein as a staining agent was made a "must" in all cases; and a routine was established to care for all of the more common eye complaints. The treatment table was stocked with the following items:

Pontocaine solution ½ per cent; fluorescein solution 5 per cent; normal salt solution; zinc sulphate solution ¼ per cent; pontocaine ½ per cent and adrenalin 1/1000 equal parts; silver nitrate 1 per cent solution; zinc sulphate ¼ per cent with 20 minims of adrenalin to the half ounce; homatropine solution 5 per cent, atropine sulphate solution 1 per cent. The nurses were instructed never to use the silver nitrate, homatropine nor atropine solutions without specific orders. They were instructed to use fluorescein followed by a copious wash of normal salt solution on each eye that was inspected. Foreign bodies that could be lifted off without curetting were to be removed and reported. Rust rings were to be referred to the office or held over until the next visit of the oculist.

Welder's flash was to be treated by the instillation of two drops of the pontocaine and adrenalin solution followed by fifteen minutes exposure to the infra-red lamp. This treatment of arc flash was found to be highly efficacious; prior to the use of the infra-red we had used cold applications. Foreign body cases were to have two drops of ½ per cent pontocaine instilled in the eye, followed by a two minute waiting period. Then the eyeball and lids were carefully examined with a loupe. The routine was to have the patient look up, down, to the right, and to the left. The upper eyelid was everted and examined and the lower cul-de-sac was inspected. If a foreign body was seen, its location, character, and size were recorded. Any abrasion of the eyeball that was found with the staining was recorded. Any patient who stated that something hit his eye with great force, and a staining area was found but no foreign body, was referred to the oculist. Such a routine in a period of two years produced only one undetected intra-ocular foreign body, and it later was discovered in our office during a routine homatropine refraction.

During our visits in the shipyard dispensary we made no discrimination as to whether the cases were compensable. Chalazia, hordeola, and conjunctivitis were all treated. Prescriptions were given exactly as we would have done in the office. We emphasize that we did explain to each non-compensable case that his case was non-compensable and that actually he was not entitled to care under the compensation set-up. This was done in order that the patient might not later complain that his case was compensable. Any injuries which

CHART I

	1943 First Half	1943 Last Half	1944 First Half	1944 Last Half	1945 First Half
Total Number of Man-Hours Worked	15,369,352	15,299,214	20,930,444	20,367,614	12,639,725
Total Number of Eye Injuries	7,376	7,082	15,052	13,686	7,497
Total Number of All Injuries	13,828	14,120	29,641	26,788	12,451
Percentage of Eye Injuries of All Injuries	53%	50%	50%	52%	60%
Total Number of Lost-Time Injuries	306	153	320	483	258
Total Number of Eye Lost-Time Injuries	169	67	116	80	25
Percentage of Eye Lost-Time Injuries of All Lost-Time Injuries	55%	44%	22%	17%	9.7%
Number of Days Lost as Result of Eye Injuries:					
(a) Foreign Bodies	242	204	217	241	28
(b) Flashes	277	185	227	173	361

CHART II

(Self Explanatory. Does not include all lost-time cases, but cases on which there was unusual expense on hospitalization and cases on which compensation was paid either with or without lost time.)

(1*)	1943 First Half	1943 Last Half	1944 First Half	1944 Last Half	1945 First Half
Number Cases	2	8	102	58	25
Number Lost Time	2	8	87–	57	14
Hospitalized	2	6	11	12	4
Compensation Paid	2	5	20	12	4
Total Days Lost	82	119	538	325	93
Eq. Salary Lost	$736.00	$978.02	$5,108.70	$3,135.16	$990.10
Compensation Paid	$4,138.55	$2,939.58	$3,711.48	$728.50	$171.08
Eyes Lost	1 total	1 - 80%	2 eyes - 30%	(None over 10%)	No visual loss (2*)
Hospital Bill	$147.17	$118.15	$601.90	$334.10	0
Medical Fees	$275.00	$186.00	$1,870.00	$416.00	$51.00

1* One eye lost total before 1943 in construction of yard.

2* One case with low visual loss and hospitalization is not yet settled.

Note: This chart is rather incomplete up to the last half of 1944. In comparing Chart I in the last half of 1944 there was only a total of 80 eye lost-time accidents, 58 of which are included on this chart. In 1943 the first half of the year there was a total of 169 cases of lost-time accidents but two of these required added expense. This can be explained by the fact that the patient's eyes were covered with patches and the Navy would not allow them to return to work until their eyes were uncovered. The last half of 1944 the majority of eye cases had no patch to wear, and if they required that, we considered them serious enough to be hospitalized in order that the recovery time would be shortened. This does not include doctor bills on cases which did not require hospitalization or on which no compensation was paid, but were seen in the office at regular fees. One case of retinal detachment, occurring four months after a head injury, is not included in this chart. It was operated on, but the procedure was not successful.

necessitated refraction, visual field studies, or slit lamp study were referred to the office.

Prior to the use of pontocaine as a routine it had been the custom of the dispensary to pass out tubes of various types of local anesthetic agents in ointment. Also, numerous types of local anesthetic agents were employed for topical anesthesia. These were all promptly stopped because of the numerous cases of sensitivity that we encountered. Some of these cases were serious enough to necessitate hospitalization. At this same time we were given a considerable quantity of penicillin ophthalmic ointment for experimental work. This was some time before it had reached the market. We found similar trouble with this. We instituted a rule that no ophthalmic ointments of any type were to be used in the dispensary unless on the specific instructions of the oculist. Many of the employees had gotten in the habit of carrying their own tubes of ointment with them, and this practice was discouraged. After the routine use of pontocaine solution was established we found no case of sensitivity among these patients. We did have one or two who were sensitive to pontocaine ointment and this added to our conclusive shunning of all ophthalmic ointments. Patients with conjunctivitis were treated routinely with zinc sulphate instillations and were instructed to return to the first-aid dispensary at regular times during the day for instillation of drops. In cases of severe conjunctivitis silver nitrate was administered by the oculist.

Following out our routine we encountered a very small number of corneal ulcers after foreign body removal. Those that were found were immediately hospitalized for local penicillin solution and hot fomentations with atropine. Generally these cases cleared in two or three days. They were sent back to work as soon as the staining area had healed over. We have used atropine routinely in all eyes showing ciliary congestion unless the individual was doing some specialized work such as fine welding; men were kept on the job in dark glasses with little or no discomfort. No discrimination was made from an age standpoint in the use of atropine. The majority of these patients were over thirty-five years of age and many were in the forty to fifty-five age group. We found one case of glaucoma during this period at the shipyard; this man had not received atropine but was suspected during a yard visit and was confirmed later in the office; he had a bilateral trephining done at a later date by one of the other oculists in the city.

We have followed a routine for three years of using no patches after a foreign body removal unless sutures of the cornea or conjunctiva were employed. We find that this results in less lost time and faster recovery of the eye. The healing seems to be more rapid and we encounter fewer cases of corneal ulcer. Most of the employees so treated much prefer this plan to the patch plan.

Chart Number III shows a comparison of the shipyard for which we were full time oculists and other industrial plants in Evansville from which we were seeing some cases. The period covered was from June, 1944, to October, 1945, the time of our contract with the shipyard. It was completed in October, 1945, at which time the employment had dropped to a point where our contract was no longer advantageous to the shipyard management. This chart shows peak employment in the spring of 1944. The number of patients seen at the ship-

CHART III

Totals on Cases Seen in Office from June, 1944, to October, 1945

	Shipyard	9 Other Plants
1. Peak employment	18,000	27,189
2. Number of patients	2,193	1,455
3. Number of visits	3,545	2,209
4. Number of visits per patient	1.6	1.5
5. Number of visits for final examination	71	57
6. Number seen only at shipyard or plant aid station and seen only at office for final examination	46	36
7. Number seen in office for injury and final examination	25	21
8. Number of patients with visual impairment on which settlement was suggested	7	13
9. Number of cases paid on for visual impairment	6 for $1,478.42	9 for $5,869.68
10. Cases continued	1 for loss of eye	0
11. Cases pending	2 malingerers not stabilized 1 unsettled (malingering)	3 not stablized*
12. Cases settled	2 malingerers for 0	1 malingerer for 0
13. Number of cases on which settlement was made without any recommendation for impairment	0	1 for total of $2,705.00

* Includes one with intra-ocular foreign body that has been removed but settlement is pending further possible improvement. He had 20/70 vision 1 year after the accident in the injured eye.

yard is proportionately higher as compared with other plants. This has nothing to do with the number of patients that we saw in the shipyard or the cases seen in other plants in their first-aid stations. The number of visits per patient is approximately the same in both groups, namely, 1.55 visits per injury. The number of patients with definite visual impairment following injury is almost twice as high in the outside group as it is in the shipyard group, although the shipyard had more accidents, more patients for final examinations, and a greater number of visits per injury.

The total number of eye injuries at the shipyard as estimated by the insuring company was about 75,000. We, of course, did not see all of these cases; many of them were handled by nurses alone in the yard and many others were handled by other oculists. It is interesting to note that of all these cases only two eyes were completely lost.

The diagnosis of malingering is very difficult to prove before our State Industrial Commission. Of a total number of four cases which we had, we were upheld three times. In the fourth case partial impairment was given the patient despite our diagnosis of malingering. In establishing a diagnosis of malingering two or three consultations with other offices is our rule. If a diagnosis of malingering is contradicted by a consultant, the patient is sent to a referee for opinion. This procedure seems to meet the favor of the Industrial Board. Sometimes different degrees of impairment are given by the several consultants, in which cases the Industrial Board averages the estimates.

In review, the following conclusions may be drawn from this report:

1. In spite of the fact that atropine was used freely on patients with ciliary congestion in all age groups, glaucoma was not precipitated in any known case.
2. The use of the eye patch is unnecessary after simple foreign body removal.
3. The number of visits per patient per injury should average about 1.55.
4. Reviewing Charts I and II: Employment in 1944 increased 34.7 per cent over employment in 1943. There was 101 per cent increase in accidents of all types, and a 98 per cent increase in eye accidents. There was 118 per cent increase in the number of lost-time accidents but an actual decrease in the eye lost-time accidents of 15 per cent under 1943, the greater decrease being in the last half of 1944. There was a 5 per cent increase in the days lost with foreign body in 1944 over 1943, and a 7 per cent decrease in days lost from welder's flash in 1944, as compared with 1943. There was a decrease in the amount paid in compensation because of visual loss in 1944 under 1943 despite the increased number of injuries.
5. Closer watch of injured patients results in more office visits but fewer compensation claims paid.
6. No routine antiseptic drops were used in any of the above cases. We feel these are not indicated as a routine measure in industrial eye injuries.

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THE ROLE OF THE CONTACT LENS IN THE CONSERVATION OF VISION

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A CONTACT lens consists of a curved shell of glass or plastic so designed as to rest upon the eyeball while avoiding actual contact with the corneal surface and the area immediately adjacent te the limbus. The space which is thus created is occupied by fluid which serves to achieve optical continuity between the tissues of the cornea and the dioptric material of the contact lens. To avoid chemical irritation of the cornea this fluid is isotonic with the tears and, in most instances, consists of 1.5 per cent solution of sodium bicarbonate. Each contact lens is constructed with two essential parts, the scleral section which supports the lens upon the surface of the eyeball, and the corneal section which covers the corneal area of the eye and upon which any dioptric correction may be ground.

At the present time all contact lenses available in this country are made of plastic. Originally they were manufactured from glass, and such lenses are still commonly in use in Europe. Because their basic material is plastic the modern contact lens is unbreakable, nonshatterable, and actually a protection for the eye against injury to the eyeball or cornea by flying particles or by abrasion. The lenses are finished with a high polish, are perfectly smooth and nonirritating to the ocular tissues.

The first contact lenses were blown from glass much as artificial glass eyes still are made today. In such lenses both the scleral and corneal portions were made without any true precision. Therefore, fitting such a lens was entirely a hit-and-miss proposition. Thirty-five years ago the Zeiss Works at Jena began to make lenses with corneal sections carefully ground to precise curves, and scleral sections ground to spherical curves. No further improvement has yet been made in the corneal section of the contact lens. However, it has been found that the eyeball is not truly spherical but, in most cases, is toric in character—that is, the eyeball has two curvatures of different radii at right angles to each other. Lenses made with toric scleral curvatures were found to permit the accurate fitting of a greater number of eyes and to afford greater comfort and longer wearing time to the patient. Nevertheless, neither comfort nor wearing time were entirely satisfactory, so molds of the eye were made to which the scleral section of the contact lens was made to conform. This molded lens has given much superior results. The most recent adaptation of the scleral section of the contact lens has made use of a conical section so that it rests upon the eyeball tangential to its surface. This lens is fitted without molding from a trial set of lenses which vary as to size and cone angle. A much higher percentage of satisfactory results is claimed for this type of contact lens.

Fitting of the contact lens involves two distinct problems: first, obtaining a scleral section which rests smoothly upon the sclera without pressure and yet fits snugly enough to prevent irritation of the palpebral conjunctiva by the abrasive action of its movements over the edges of the lens; second, a corneal section must be added to the scleral portion so that the corneal surface is cleared at all points and over an area of between 2.0 and 4.0 mm. from the limbus. After this has been accomplished, the lens will move freely with the eye without discomfort to the patient and without inflicting injury upon the surface or the margins of the cornea. Refraction may now be performed with the lens in place and the resulting correction incorporated into the finished prescription lens.

The essential optical principles which govern the correction of refractive error by contact lenses are no different from those which apply to the common spectacle lens. The contact lens is particularly efficient in correcting high degrees of astigmatism, whether myopic or hyperopic. This is true because of the fact that astigmatism is chiefly a function of the corneal curvature. When, therefore, a contact lens is placed in an astigmatic eye, the presence of the fluid between the corneal and the lens surfaces (since the fluid has an index of refraction very close to that of the corneal tissues) serves, in effect, to extend the corneal surface to the anterior surface of the contact lens. Since the surface of the corneal section of the contact lens is spherically ground, all astigmatism derived from defects of corneal curvature is eliminated. The only remaining astigmatism is that of the lens which is seldom of any magnitude. It is rare, indeed, that lenticular astigmatism totals more than 0.75 diopters and, in the great majority of cases, it is much less.

The corneal surface is the greatest factor in determining the refractive error of the eye, for the total refractive power of the cornea is 31.80 diopters as compared with 19.69 diopters for the crystalline lens.[1] Therefore, a contact lens which can eliminate and modify the corneal curvature is highly efficient in correcting very high hyperopic er myopic refractive errors. At the same time the contact lens eliminates the undesirable aberrations which are always present when spectacle lenses are used to correct refractive errors of high degree. Because the contact lens rests upon the surface of

[1] Cowan, Alfred: *Ophthalmic Optics*, Second Edition. F. A. Davis Company, Philadelphia, 1928.

the eyeball it moves with the movements of the eye. Consequently there is no variation in the total available correction due to decentration of the cornea from the optical center of the correcting lens. The contact lens thus affords its wearer a wide, clear field with maximum available dioptric power throughout a wide range of ocular motion. Since this improvement is accomplished without the necessity for the eye to look through a great thickness of glass, it is evident that eyes with very great refractive errors, by means of contact lenses, can be provided with an acuity of vision which is definitely superior to that attainable by the use of spectacle lenses.

Aphakia is another refractive condition which is best corrected by the use of the contact lens. A contact lens eliminates the necessity for the thick, heavy cataract lens and, at the same time, avoids the dioptric aberrations, and the induction of vertical prismatic power which inevitably produces diplopia in the monocular aphakic. Because the contact lens does not displace the principal points of the ocular dioptric system to the same degree as does the spectacle lens, there will result very much less disparity in image size between the normal and aphakic eye.

Where refractive error of much greater degree or of opposite sign is found in one eye as compared to the other, the contact lens will prove to be an extremely useful means to bring about the restoration of normal binocular vision. The induction of prism when the eye looks away from the optical center of the correcting lenses, and great disparity in retinal image size in the two eyes are the common sources of difficulty in such cases—difficulties which can be eliminated by the use of contact lenses.

Irregular astigmatism due to conical cornea, developmental anomalies of the corneal structure, or corneal scarring is not amenable to correction by the spectacle lens. The contact lens, by means of its ability to eliminate the corneal curvature as a factor in the refraction of light in the eye, is capable of restoring such cases to a normal visual acuity. It must, however, be understood that the contact lens has no therapeutic value in stopping the progress of a case of conical cornea.

There are certain other cases where refractive error may not be unusually great and where adequate correction of that error may be obtained with spectacle lenses, which require the use of a contact lens by reason of occupational necessity. This type of patient is typified by the athlete who cannot endanger his eyes by wearing spectacle lenses during an athletic contest, or the actor who cannot place himself out of character by wearing glasses. These individuals can enjoy the acuity of vision their occupation requires minus the disadvantages of the spectacle lens by the wearing of contact lenses.

Contact lenses present certain distinct disadvantages as compared to the spectacle lens. They cannot be worn for an unlimited length of time. Depending upon the accuracy of the physical fit to the contours of the sclera and the adequacy of clearance between the lens and the cornea, irritation of the ocular tissues may result which requires removal of the lenses. If these factors are well controlled contact lenses usually can be worn over a period of four hours by the average patient. At approximately that time the patient notes a haziness of vision with the appearance of colored halos about lights which are exact duplicates of those seen by patients with glaucoma. Both the haze and the halos are the result of corneal edema which has resulted either by osmosis of water into the cornea from prolonged contact with the fluid beneath the contact lens or by actual mechanical injury of the corneal epithelium by the contact lens itself. In many individuals the appearance of haze may be delayed up to eight hours or even much longer. In any case, removal of the lenses brings about clearing of the cornea within a period of thirty minutes, after which the lenses may be reinserted and worn for another period of from four to eight hours without any injury to the ocular tissues. Continued wearing of the lenses appears to increase the tolerance of the patient so that there occurs a gradual and continued improvement in comfort and wearing time.

Presbyopes and aphakics cannot make use of contact lenses for close work without the aid of supplementary spectacle lenses. Since the correction in the corneal section of the contact lens becomes, by extension, a part of the patient's own cornea, it is obvious that no bifocal addition could possibly be added for use at the near point.

Summary

Contact lenses are important tools serving the oculist in the conservation of vision. Where no other means avail, vision can be restored by contact lenses in cases of irregular astigmatism due to conical cornea, developmental anomalies of the corneal structure, or corneal scarring.

Contact lenses are vitally necessary for certain patients engaged in occupations where good vision is essential but where circumstances render impossible the wearing of spectacle lenses.

Contact lenses afford improved vision over that available by the use of standard spectacle lenses in the following conditions:

1. Myopia of very high degree.
2. Aphakia or hyperopia of very high degree.
3. Astigmatism, hyperopic or myopic of high degree.
4. Aniseikonia of Aphakia.
5. Anisometropia.
6. Antimetropia.

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ACUTE IRITIS

Including Acute Iridocyclitis and Acute Uveitis

Byron N. Lingeman, M.D.

CRAWFORDSVILLE

THE general practitioner has an important, two-fold responsibility in cases involving acute inflammation of the iris: (1) in attempting to make an early diagnosis in order that proper treatment can be instituted promptly; and (2) to help determine the etiology.

Obviously the family physician does not wish to send every case with inflamed or "red eyes" to the eye physician, nor is it always practical to do so. Neither does he wish to delay the diagnosis too long and take a chance on the development of serious sequelae which might cause a permanent impairment of the patient's vision. Some cases are extremely difficult to diagnose during the first day or so, requiring the use of mild mydriatics (paredrine, neosynephrin, euphthalmine) to demonstrate sluggish and irregular dilatation of the pupil, and the use of a slit lamp to reveal cloudiness of the aqueous. However, in most cases, if the family physician will keep in mind a few signs and symptoms, he will be able to make a diagnosis and outline the proper treatment or refer the patient to an eye physician early in the disease.

The two most important conditions sometimes confused with iritis as the cause of inflamed eyes are acute conjunctivitis and acute glaucoma. Other causes of "red eyes" are: a foreign body on the cornea, corneal ulcer, and subconjunctival hemorrhage. These can usually be diagnosed easily with a good light, such as a flash light, shining upon the eyeball at an angle. If there is much mucopurulent secretion and the lids stick together, it is probably a case of acute conjunctivitis. If there is only watery secretion, the eye is painful, and the pupil small, it is probably iritis. If the pupil is dilated it is probably glaucoma.

In glaucoma the eyeball feels firm on alternate pressure with the tips of the forefingers as compared with the other eye, or as determined by pressure made on the cornea by the tip of a medicine dropper after the use of a local anesthetic, or better still, by the use of the Schiötz tonometer. Also, the pain is very severe, radiating to the forehead and temple, and is frequently accompanied by vomiting. Vision is much decreased, the cornea steamy, and tenderness marked.

In acute iritis the pain is not usually so severe, the tenderness is marked, tension low, and dust-like opacities can be seen on the cornea and lens capsule with oblique illumination and the ophthalmoscope. The iris markings are indistinct and muddy, the aqueous is cloudy, and vision impaired.

In acute conjunctivitis the pain is absent, or there is only a sensation of irritation and sensitiveness to light, there may be slight tenderness, vision is normal except for blurring from the secretion, tension is normal, and media clear. It is important to be able to distinguish between acute iritis and acute glaucoma because the treatment of the two conditions is diametrically opposite.

The most commonly accepted causes of primary iritis or iridocyclitis, according to Fralick et al[1] are: syphilis, tuberculosis, focal infections, arthritis, gonorrhea, herpes, sarcoid, and rheumatic conditions. To these should be added Brucella infections, allergy to molds, pollens, weeds, and foods, and a few cases of unknown etiology. To diagnose these conditions requires teamwork among the general practitioner, laboratory technician, and eye physician. As indicated, examination of the teeth, including x-ray, should be done, also tonsils, sinuses, gall bladder, prostate gland, t.b. skin tests and x-ray of chest, Kahn blood test, laboratory tests for Brucella, gonorrhea, sarcoid, allergy, et cetera. It is possible for a patient to give a positive test for tuberculosis or syphilis and his iritis still be from some other cause. It is important to remember that primary iritis is caused from infection or a condition within the body and not from without.

According to Brown,[2] so-called nonspecific types of uveal inflammation may be due to the sensitization of the uveal tract by the circulating protein products of organisms or altered tissue on a remote focus. It is the reaction of the uveal tract, iris, ciliary body, choroid, against these protein products which gives rise to the clinical picture of iritis or iridocyclitis as we see them. He was able experimentally to produce sensitization of the uveal tract of rabbits by injecting proteins such as horse serum, egg white, and dead organisms or their toxins taken from broth filtrates. By implanting live organisms taken from dental foci into the abdominal wall of a rabbit which had been sensitized by the same strain he was able to produce inflammation of the uveal tract. He also found that this reaction could be prevented or "interfered with" by the injection of still another protein which produced antibodies in the aqueous. He states that, "Thus, a cycle was suggested consisting of local sensitization, activation, and tempo-

1. Fralick, F. Bruce; Cooper, James H., and Armstrong, Richard C.: Uveitis with Secondary Glaucoma, *Trans. Am. Academy Ophth. and Otolog.*, Nov.-Dec., 92-99. 1942.
2. Brown, Albert L.: Uveitis: The Role of Intraocular Typhoid-Antibody in Treatment, *Am. J. Ophth.* 20: 583-591. June, 1937.

rary desensitization." His observations led him to believe that typhoid vaccine or "H" antigen was best to produce the antibodies to interfere with this cycle, and this has developed into a valuable addition in the treatment of iritis.

In an article on Brucellosis, Krause[3] states that "This is a widespread common disease, frequently unrecognized clinically and it produces ocular disease more commonly than realized. Iridocyclitis, uveitis, and choroidoretinitis are the usual ocular diseases and these may simulate tuberculosis or syphilitic eye disease." Diagnosis is difficult, requiring careful history and laboratory tests.

A good description of the pathology of iritis is given in an article by Fralick et al[1] as follows: "The iris is made up of blood vessels and smooth muscle fibers held together by a very loose, spongy stroma. Inflammation of the iris is essentially the same process that occurs in other connective tissue: namely, dilatation of the blood vessels, impairment of the capillary walls, production of a highly viscous albuminous lymph into the tissue spaces and either leukocytic or lymphocytic infiltration. Due to the vascularity of the iris, the distribution of the vessels and the looseness of the connective tissue stroma, distinctive results are seen when inflammation takes place. The heavy albuminous exudates find their way into the aqueous, increasing its specific gravity and turbidity, as evidenced by the slit lamp. The increase in specific gravity, fibrin and cellular content of the aqueous makes its escape through the filtration angle more difficult and may in turn produce a secondary rise in intraocular tension." (Glaucoma.) Also, "The periphery of the iris is brought in close contact with the anterior lens capsule, thus paving the way for the formation of posterior synechia (adhesions between the iris and capsule of the lens). The base of the iris is pushed forward to encrouch on the filtration angle and anterior synechia are produced, again increasing the possibility of secondary glaucoma. A tonometer should be used freely as the only accurate means to early discovery of secondary rise in tension."

All authorities agree that the most important measure in the treatment of iritis is prompt dilatation of the pupil. Gifford[4] states that "Promptness is exceedingly important as synechia form very quickly and soon become so firm that later efforts to break them up are unavailing. Atropine sulfate in 1 per cent solution or ointment is usually tried and if successful in producing full mydriasis is continued in sufficient amount to maintain this condition during the period of active inflammation. Atropine is of value not only for the mydriasis produced, but also because it paralyzes the ciliary body and hence relieves ciliary spasm, an important source of pain."

In cases of severe pain atropine is best combined with cocaine 2 per cent and used frequently at first until complete dilatation is obtained. If this does not break down the adhesions, then epinephrine packs placed in the upper and lower fornices for several minutes are indicated. In stubborn cases, two minims each of 2 per cent atropine, 2 per cent cocaine, and 1:1000 epinephrine may be injected subconjunctivally. The pupil should be kept well dilated until all the redness of the eye has cleared up, otherwise there might be a relapse.

Most important is the determination of the cause. If due to syphilis, antiluetic treatment should be started at once. Klander and Dublin[5] claim better results within penicillin in these cases than with chemotherapy. They feel that watching for the Herxheimer reaction with the slit lamp is of some importance in diagnosis. Knight and Schachat[6] report good results in the treatment of syphilitic iritis with the Kettering Hypertherm, keeping the body temperature up to 105 to 106 F. for five hours.

Prompt elimination of all foci of infection is important, the two most common ones being the teeth and tonsils. Heat is a most valuable remedy in relieving pain and ciliary spasm. It may be applied almost continuously by means of hot packs or the infra-red lamp. Tablets containing codeine, grs. ½, may be necessary to relieve pain.

The use of typhoid "H" antigen, as described by Brown,[2] is of great value in most cases. He states that the average effective dose was found to be twenty to twenty-five million, repeated every thirty-six to forty-eight hours, depending upon individual reaction. Twelve to twenty-four hours after the third injection, paracentesis of the anterior chamber is performed, which markedly increases the height of the titre in the aqueous. There is very little shock with this treatment and repeated paracentesis is without danger. Other ophthalmologists agree that this treatment materially lessens the duration and severity of the disease.

For chronic tuberculous iridocyclitis Gifford[4] states that: "Rest and special diet should be advised and in many cases a course of tuberculin. Beginning with minute doses by subcutaneous injection, the amounts are gradually increased until one to five mg. of old tuberculin is tolerated without reaction." Many physicians continue to give, more or less empirically, large doses of sodium salicylate, up to 120 to 150 grains per day during acute symptoms.

For secondary glaucoma, paracentesis of the anterior chamber, as described by Fralick et al[1] is indicated. These authors advise the use of atropine during the active stage of inflammation even if the tension is increased; then, later, miotics can be used. "Where foreign protein has been used

3. Krause, Arlington C.: Ocular Brucellosis, *Ill. Med. J.* 87:306-310. June, 1945.
4. Gifford, Sanford R.: *Textbook of Ophthalmology*, 212-222. W. B. Saunders Co. 1938.
5. Klander, Joseph V., and Dublin, George Q.: Syphilitic Iritis with Particular Reference to the Herxheimer Reaction As a Diagnostic Aid and Response to Different Methods of Treatment, Including Penicillin Therapy, *Arch. Ophth.*, 33:416. May 1945.
6. Knight, Harry C., and Schachat, Walter S.: Syphilitic Ocular Conditions, *Arch. Ophth.*, 35:276. March, 1946.

previously, evacuation of the anterior chamber washes out the cellular and fibrinous aqueous, clears out the filtration angle, and increases the antibody titre. It is best done subconjunctivally in the corneal periphery. The aqueous should be allowed to escape slowly. . . . Should the tension rise again, the anterior chamber may be re-opened by passing a spatula between the lips of the paracentesis wound. This is repeated, within reason, until the iritis is under control, lessening the edema and infiltration of the iris and the celiular and fibrinous exudate." If the tension is not controlled by these methods, iridectomy is the operation of choice.

If Brucella is thought to be the cause, Krause[6] advises the use of atropine, fever therapy with typhoid vaccine, and a vaccine of brucella or brucellergin may be used.

Bothman[7] believes that some cases of iritis are due to allergy from molds, pollens, weeds, or foods, and advises treatment for these conditions by elimination and desensitization after skin testing.

The average, full-blown case of iritis lasts about five weeks. The pain may be very severe most of this time. Other patients may have repeated, mild attacks, lasting only a few days with little discomfort. About all that is necessary is to dilate the pupil, put on some dark glasses, advise hot compresses, and give occasionally a mild protein injection. I recently had under treatment a severe case of iridocyclitis following herpes zoster opthalmicus. Apparently the family physician did not recognize the seriousness of the disease because the patient was not sent in until five or six weeks after onset. Recovery has been slow.

7. Bothman, Louis: Allergic Iritis. *Ill. Med. J.*, 124, March, 1946.

Summary

(1) Iritis, together with iridocyclitis and uveitis, are common eye diseases, frequently very painful, and sometimes resulting in permanent crippling of the eye.

(2) Early diagnosis should be made in order that proper treatment may be instituted.

(3) Careful search for the etiological factor is necessary, requiring co-operation among the general practitioner, eye physician, and laboratory.

(4) Prompt dilatation of the pupil with atropine, elimination of foci of infection, and treatment of the etiological factor, typhoid "H" antigen, followed by paracentesis of anterior chamber, are important items in the treatment.

(5) The eye should be watched for secondary glaucoma.

THE USE OF PENICILLIN LOCALLY IN THE EYE*

Malcolm E. Miller, M.D.

GOSHEN

PENICILLIN has demonstrated its remarkable effectiveness in the prophylaxis and treatment of ocular infections to an extent equal to that of infections elsewhere in the body. The ophthalmologist now has a weapon enabling him to cope with problems successfully which heretofore resisted the conventional forms of treatment.

To use the drug locally in the eye has been the subject of considerable clinical and experimental investigation since the first reports by the Oxford investigators[1] in 1941, which were significantly encouraging. Subsequently, Florey and Florey[2] reported the use of penicillin locally in the treatment of eighty-nine infections of the eye. Forty-six of their cases were blepharitis, eighteen were acute conjunctivitis, and nineteen involved acute infections of the lacrimal sac. The treatment consisted of the use of an ointment containing 600-800 U. of penicillin in vaseline, applications being made every hour during the day and every two hours at night. According to their report, this form of treatment proved effective even in cases of acute conjunctivitis complicated by corneal ulceration.

Following this report, other investigators made known their findings and to date hundreds of publications have further demonstrated the effectiveness of this drug in ocular infections. The purpose of this paper is an attempt to evaluate these reports and, with the investigational and clinical experience of the author in the use of penicillin, arrive at some reasonable conclusion as to the use and limitations of the drug locally in the eye.

The early investigators who were interested in the ophthalmological application of the drug concerned themselves with essentially three main problems:

1. The concentration of penicillin obtained in the ocular tissues and fluids.
2. The effectiveness of penicillin against experimental ocular infections.
3. The treatment and clinical results obtained with penicillin.

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

1. Abraham, E. P.; Chain, E.; Fletcher, C. M.; Gardner, A. D.; Jennings, M. A., and Florey, H. W.: Further Observations on Penicillin. *Lancet.* 2:177-188; 189 (Aug.) 1941.
2. Florey, M. E., and Florey, H. W.: General and Local Administration of Penicillin. *Lancet.* 1:387; March 27, 1943.

Problem One

The Oxford investigators[1] (Abraham, Chain, Fletcher, et al.), above referred to, reported that following systemic administration of penicillin tears were found to exert no antibacterial activity. Rammelkamp and Keefer[3] were also unable to demonstrate the presence of any penicillin activity in tears following the parenteral administration of penicillin. However, Struble and Bellows[4] report that if large amounts of penicillin are administered the substance can be demonstrated readily in the tears of experimental animals. Dogs which received intravenously 12,800 units of penicillin per kilogram of body weight were found to contain as high as 3.19 units of penicillin per cubic centimeter fifteen minutes after the injection had been made. Penicillin activity was still detectable in the tears of these animals at the end of half an hour. These observers also demonstrated the presence of penicillin activity in the conjunctiva, the sclera, extraocular muscles, the chorioretinal layer, and the aqueous humor. The concentration of penicillin in the cornea and the vitreous humor was small, and none could be demonstrated in the lens. The above is understandable in view of the avascularity of these tissues.

When penicillin is given in adequate clinical doses, however, the concentration in the ocular tissues and fluids is so slight that it is not detectable by present biologic methods. When the eyes are inflamed, penicillin levels are somewhat increased. On the other hand, penicillin administered locally does produce high concentration in certain tissues. It has been shown by Von Sallmann and Meyer[5] that repeated instillations of penicillin drops failed to affect significantly aqueous humor concentration. Iontophoresis, subconjunctival and corneal bath techniques do produce higher concentration in the anterior segment.

Recently Von Sallmann, Grosse, and Marsh[6] have shown that ophthalmic ointment prepared with the calcium salt penetrated the cornea of rabbits, and resulted in an effective content of penicillin in the aqueous.

Local methods do not create increased levels of penicillin in the vitreous. Anterior chamber injections have been performed in experimental animals with little evident damage at the site of the needle puncture, but intravitreous injections have occasionally resulted in opacities.

Notwithstanding the above, the possibility that traces of penicillin might be present in the ocular tissues and fluids following systemic administration of fairly large amounts, and that some clinical effect might follow, Herrell[7] recommended that for the treatment of infections of the eye, penicillin should be applied locally as well as administered systemically.

Problem Two

The experimental use of penicillin locally by the early investigators involved ocular infections due to Staphylococcus aureus. In the cases reported by Florey,[2] the predominating organism was Staphylococcus aureous. Lyons[8] reported the satisfactory treatment of three patients who had acute conjunctivitis due to this organism. Later, Cashell[9] further reported satisfactory results in certain ocular infections treated with penicillin locally. He found the drug effective against a variety of organisms, including Staphylococcus aureus, Streptococcus pyogenes, the pneumococcus, and Neisseria gonorrhoeae. Cashell recommended the use of either drops or ointment of a concentration of 500 units per cubic centimeter or per gram. His work involved the following types of infections suitable for treatment: 1. Acute conjunctivitis and blepharitis due to Staphylococcus aureus, Streptococci, or pneumococci. 2. Chronic blepharitis. 3. Infected corneal ulcers. 4. Perforating corneal injuries wherein there was risk of intraocular infection.

Following Cashell's publication, Crawford and King[10] reported on the successful local use of penicillin in the treatment of various infections of the eyes and margins of the lids. Milner[11] further reported satisfactory results in the treatment of acute infections of the eyes, although it was his opinion that penicillin was of little value in the treatment of chronic conjunctivitis.

Some twenty bacteria, clinically sensitive to penicillin, have been described. Those occurring in ocular diseases[12] include the alpha, beta, and gamma Streptococci, Staphylococcus aureus and albus, Neisseria gonorrhoeae, Neisseria intracellularis, Corynebacterium diphtheriae (mitis), Clostridium welchii, Actinomyces bovis, Treponema pallidum, and diphtheroids. The most highly sensitive organisms to penicillin are the beta hemolytic Streptococcus, the Gonococcus, and some strains of Staphylococci. The latter vary from extreme sensitiveness to extreme resistance.

3. Rammelkamp, C. H., and Keefer, C. S.: Absorption, Excretion and Distribution of Penicillin. *J. Clin. Investigation.* 22:425-437 (May) 1943.
4. Struble, G. C., and Bellows, J. G.: Studies on the Distribution of Penicillin in the Eye; and Its Clinical Application. *J.A.M.A.* 125:685-699 (July) 1944.
5. Von Sallmann, L.; Meyer, K.; and Di Grandi, J.: Penetration of Penicillin into the Eyes. *Arch. Ophth.* 31:1 (Jan.) 1944.
6. Von Sallmann, L.; Grosso and Marsh: Ophthalmic Penicillin Ointments. *Arch. Ophth.* 36:3 (Sept.) 1946.
7. Herrell, W. E.: *Penicillin and Other Anti-Biotic Agents.* p. 76 and p. 207. W. B. Saunders Co., Phila., 1946.
8. Lyons, C.: Penicillin Therapy of Surgical Infections in the U. S. Army; A Report. *J.A.M.A.* 123:1007-1008 (Dec.) 1943.
9. Cashell, G. T.: Treatment of Ocular Infections With Penicillin. *Brit. Med. J.* 1:420 (Mar.) 1944.
10. Crawford, T., and King, E. F.: The Value of Penicillin in the Treatment of Superficial Infections of the Eyes and Lid Margins. *Brit. J. Ophth.* 28:377-383 (Aug.) 1944.
11. Milner, J. G.: Penicillin in Ophthalmology. *Brit. Med. J.* 2:175 (Aug.) 1944.
12. Stein, S. H.: Treatment of Chronic Blepharo-Conjunctivitis with Penicillin Ointment. *Arch. Ophth.* 35:6 (June) 1946.

Problem Three

Let us now consider the third of the problems mentioned, namely, the treatment and clinical results obtained with the use of penicillin locally in the eye. The following methods have been used for the local administration of the drug:

1. Solution instilled as drops in the conjunctival sac, or applied as a corneal bath.
2. Ointment.
3. Crystalline penicillin.
4. Iontophoresis.
5. Subconjunctival injection.
6. Anterior chamber injection.
7. Intravitreous injection.
8. Intra-lenticular injection.

As stated by Florey and Florey,[2] "The problem of using penicillin locally is that of devising some means to apply a very soluble and diffusible substance so that a bacteriostatic concentration is constantly maintained at every point where there are infecting organisms." Various media of this type offering even dispersion of penicillin in high concentration over the infected area are offered in various forms of ophthalmic ointments. These media have a tendency to hold the penicillin at the site of application, and liberate it slowly so that it is not too rapidly absorbed. An anhydrous base favors retention of the potency of the penicillin. That such a preparation is well tolerated by the eye has been shown by Cashell.[9]

Great care must be exercised in the prescribing of a local penicillin preparation, for successful treatment of bacterial infections of the eye depends on pathogens which are susceptible. Therefore, since many ocular infections are self-limited, recovery may or may not be expedited by the use of penicillin and results may be erroneously credited to the drug.

Solutions of penicillin instilled as drops or used as a corneal bath have contained from 500 units per cubic centimeter to 10,000 units per cubic centimeter. A concentration of 1,000 units is generally employed, and is of sufficient potency to result in satisfactory treatment. Isotonic sodium chloride solution is the preferred diluent, but distilled water may be used.

Both hydrous and anhydrous bases have been used in the preparation of penicillin ointments. Florey and Florey[2] used pure petrolatum. Keyes[13] applied penicillin in a cold cream and wool fat base. Cashell[9] employed a lanette wax base. Others have used an anhydrous wool fat and oil in water emulsion, Carbowax, wool fat and petrolatum, and Hydrosarb. Both hydrous and anhydrous vegetable oil bases have also been tried.

The potency of the ointment product most generally used is 1,000 units per gram, though 500 to 2,000 units per gram have been recommended. According to Von Sallmann et al,[6] the sodium salt of penicillin incorporated in a hydrous vegetable oil base most completely met the requirements of an ointment that was non-irritating, relatively stable, and had good penetrating ability.

Ainslie[14] has reported the successful use of crystalline penicillin in a case of hypopyon which followed lens extraction. Juler and Johnson[15] found crystals of penicillin effective in the treatment of infected corneal ulcers, infiltration scars and wounds, and intra-ocular operations. The authors emphasize the necessity for gently rubbing in the crystals.

Penicillin administered by iontophoresis has produced dramatic results in the central type of corneal ulcer and in post-operative cataract infections. A solution containing 1,000 to 5,000 units of penicillin per cubic centimeter may be used.

To inject penicillin subconjunctivally or into the anterior chamber does not seem entirely justifiable. The simpler and less hazardous aforementioned methods of administering the drug for anterior segment infections has, for the most part, proved sufficiently effective. Not enough clinical evidence has been compiled to encourage intravitreous or intra-lenticular injections.

Let us, for the remainder of this discussion, consider a few of the more common conditions that will respond to the application of penicillin locally. Infections of the border of the lids, notably Staphylococcus blepharitis, have been treated with penicillin and encouraging results have been reported by Cashell,[9] Bellows,[16] Stein,[12] and others. Thygeson[17] reports a series of cases of blepharitis in military personnel in which penicillin solution (500 units per cubic centimeter) was instilled as drops four times daily, and an ointment containing 1,000 units per gram was applied night and morning. He states that some cases were cured in a week, but relapses were frequent. Further, he found penicillin to be more effective than sulfathiazole or sulfadiazine. Staphylococcic blepharitis complicated by meibomitis is not satisfactorily controlled by local penicillin therapy due to the inability of penicillin to penetrate into the meibomian glands in appreciable amounts. Blepharoconjunctivitis has been controlled and in many instances completely cured by local application of penicillin ointment especially when of Staphylococcal origin. Infections of the lacrimal sac have responded to

13. Keyes, J.: Penicillin in Ophthalmology. *J.A.M.A.* 126:610 (Nov.) 1944.

14. Ainslie, D.: The Use of Solid Penicillin in a Case of Endophthalmitis Following Lens Extraction. *Brit. J. Ophth.* 30:208 (Apr.) 1946.

15. Juler, F., and Johnson, G. T.: The Use of Crystalline Penicillin in Corneal and Intraocular Infections. *Brit. J. Ophth.* 30:204 (Apr.) 1946.

16. Bellows, J. G.: Penicillin Therapy in Ocular Infections. *Am. J. Ophth.* 27:1206 (Nov.) 1944.

17. Thygeson, P.: The Etiology and Treatment of Blepharitis; A Study in Military Personnel. *Mil. Surgeon.* 98:279 (Apr.) 1946.

local therapy according to Keefer, Herwick, Van Winckle, and Putnam.[18]

Acute infections of the conjunctiva, especially those of a purulent character when due to susceptible organisms, respond dramatically to local therapy, whether the penicillin is in the form of ointment, drops, or bath. The use of a solution containing 1,000 units per cubic centimeter necessitates frequent applications, usually at thirty minute intervals. Penicillin ointments containing at least 1,000 units per gram can be applied at from one to three hour intervals. Acute Staphylococcic conjunctivitis can often be completely cured within forty-eight hours. It is also the treatment of choice in infections caused by Streptococci, pneumococci, Neisseria intracellularis, and Neisseria catarrhalis.

Gonorrheal ophthalmia has been successfully treated by the author[19] by local applications of penicillin ointment together with vigorous symptomatic measures of cleanliness, irrigations, ice compresses, atropine, et cetera. Selig[20] reports the cure of a case of gonorrheal ophthalmia which failed to respond to systemic treatment with subconjunctival injection of penicillin followed by instillation of the drug into the conjunctival sac as a corneal bath. It is recommended that systemic administration of penicillin accompany the local use of the drug. There is good evidence that when fairly large amounts of penicillin are administered systemically some penetration into the eye occurs. For this reason Herrell[7] has found it desirable to use rather large amounts of penicillin (50,000 units every three hours) for systemic treatment combined with local instillation.

Infected corneal ulcers, when due to susceptible organisms, often respond readily to the local form of treatment. Even cultures obtained in ulcerative keratitis of pneumococcic origin have become negative in twenty-four hours following the application of an ointment containing penicillin. Mahoney[21] reports that corneal ulcers even though complicated by hypopyon will respond much more quickly and more surely now that penicillin has been added to our armamentarium. It has been stated previously that iontophoresis has produced dramatic results in the central type of corneal ulcer. Struble and Bellows[22] have described a contact eye cup which has proven satisfactory for instilling penicillin solution into the anterior segment of the globe. According to the authors, contamination of corneal lesions from the surfaces of the skin and lashes can be prevented and penicillin can be kept in contact with the cornea for long periods without discomfort to the patient and without loss or dilution through the lacrimal apparatus.

Deep recurrences of rosacea keratitis have been reported successfully treated by the application of solid penicillin. The crystals must be applied after the use of a local anesthetic or following orbital injection of procaine.

The incidence of postoperative intra-ocular infections has been lessened by the use of penicillin locally. Such infections, if they do occur, can be more readily controlled according to Ainslie[14] and others. Filtration scars and wounds and penetrating injuries of the eye should be treated locally with penicillin as well as systemically. Favorable reports in the literature are lacking in the successful treatment of uveitis and scleritis by these methods. A case of acute scleritis under treatment by the author at this writing has failed to respond to intensive local and systemic penicillin therapy. Local irritation as a result of the drug or its vehicle is not common.

In conclusion, the local application of penicillin in the eye affords the ophthalmologist an effective means of controlling many ocular infections. The drug can be effective only against susceptible organisms, and since many eye infections are self-limited, too much evaluation must not be credited to penicillin unless the organism has been previously determined.

18. Keefer, C. S.; Herwick, R. P.; Van Winckle, W., Jr.; and Putnam, L. E.: New Dosage Forms of Penicillin. *J.A.M.A.* 128:1161 (Aug.) 1945.
19. Miller, Malcolm E.: Gonorrheal Ophthalmia. *J. Ind. St. Med. Assn.* 37:12 (Dec.) 1944.
20. Selig, C. A.: Gonorrheal Ophthalmia; Treatment With Intra-Ocular Penicillin. Report of a Case. *U.S. Naval Med. Bull.* 44:389 (Feb.) 1945.
21. Mahoney, C. L.: Penicillin in Ophthalmology. *J. Ind. St. Med. Assn.* 39:5 (May) 1946.
22. Struble, G. C., and Bellows, J. G.: Contact Eye Cup for Corneal Baths and Solutions of Penicillin. *Arch. Ophth.* 35:173 (Feb.) 1946.

GENERAL PRACTICE MEETING AT LOUISVILLE, WEDNESDAY, MAY 22, 1947

The University of Louisville School of Medicine will be host to the Indiana Board of General Practice of Medicine at Louisville General Hospital, 323 East Chestnut Street, Louisville, Kentucky, Wednesday, May 22, 1947.

Dr. Harry E. Klepinger, of Lafayette, president of the Indiana General Practice Board, invites all general practitioners to attend this meeting.

THE TREATMENT OF CHRONIC SUPPURATIVE OTITIS MEDIA*

ERNEST L. DIETL, M.D.

SOUTH BEND

OUR aim in arriving at a most successful treatment of chronic suppurative otitis media is to stimulate and encourage the general practitioner in the treatment of chronic discharging ears. There is a nationwide program on, as we all know, on the conservation of hearing. We must all, therefore, be informed as to what this program is accomplishing. We know that a large percentage of deafness in children is due to chronic middle ear infection. In my own county, and I hope every county in every state has a similar program, all the school children are examined in the tenth and eleventh grades. On this medical examining team is a well qualified otologist who carefully examines the ears for any chronic infection of the middle ear. It is surprising even today that in rural districts one can find about 2 per cent of middle ear infections going untreated. This seems to me uncalled for.

Our chief aim is to prevent deafness due to chronic disease of the middle ear and to eliminate complications from this infectious process. Chronic suppurative otitis media, if gone untreated, causes a gradual loss of hearing and subjects the patient to the possible following complications: (1) brain abscess, (2) meningitis, (3) lateral sinus thrombosis, (4) septicemia, (5) acute labyrinthitis, (6) facial paralysis, and (7) subperiosteal abscess.

The patient will, as a rule, never bother to seek treatment because it causes no pain or discomfort, and they gradually become accustomed to the discharge and loss of hearing. It is therefore up to the family physician to encourage treatment if we ever hope to effect a cure.

The treatment of chronic suppurative otitis media, as the name implies, infection in the middle ear, must be carried out thoroughly or else our regime of treatment will be a failure, and we will have failed to benefit the patient in any way. It is a disease to which various methods of treatment have been applied, and which has given the general practitioner, as well as the otologist, no end of trouble in arriving at the best method of treatment. We want to erase from everyone's mind the old adage in regard to chronic discharging ears in children, of leaving them alone, they will outgrow it, or the old superstition that if the discharge is stopped it will break out somewhere else in the body.

In the past decades our concepts of chronic suppurative otitis media have changed. It used to be thought that an element of time was an important etiological factor in this disease, but now it seems that this is not at all an important factor.

Chronic suppurative otitis media is a chronic inflammation of the middle ear cavity, characterized by a persistent flow of mucus or pus from one or more perforations in the drum membrane. The chief cause of chronic middle ear infections is an acute attack of the disease in which either the patient's resistance is below par or the treatment is inadequate. Chronic infections of the upper respiratory tract, infected nasal accessory sinuses, or diseased adenoids and tonsils will tend to keep up an infection in the middle ear, especially the catarrhal type. About 20 per cent of all chronic suppurative otitis media cases can be traced to an acute infectious disease of childhood, scarlet fever, measles, diphtheria, whooping cough, pneumonia, and influenza being the chief offenders.

Careful examination is most important in arriving at a conclusive diagnosis and regime of treatment; type of discharge, mucoid or purulent, blood-streaked, fetid odor, or odorless, is most important. Also most important is an audiometric reading to get a true picture of the exact loss of hearing.

For simplicity, let us take the two common types of discharge from the ear. The mucoid type, which may or may not have an odor, is usually thick and tenacious. The other type is very foul-smelling and of a lusty grayish-yellow color. One may see small, white, shiny, greasy flakes, which is characteristic of cholesteatoma. It is well to state here what we mean by cholesteatoma. A cholesteatoma is an accumulation of horny and desquamated epidermis and cholesterin crystals. Cholesteatoma is described as an ingrowth of squamous epithelium through a marginal perforation of the ear drum.

Bacteriologic examination of the discharge from chronic middle ear suppuration offers little of practical value. Secondary invaders such as the staphylococcic, the bacilli proteous, and pyocyaneus are invariably found in aural discharge which has acquired the characteristics of chronicity.

The type of discharge which is thin and mucoid with little or no odor usually is seen with an anterior quadrant or central perforation of the drum membrane, and the discharge is chiefly from the eustachian tube. Evidence of the destructive disease in the middle ear is lacking. This type of discharge is increased and more purulent during head colds. Contributing factors in the continua-

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

tion of the discharge are pathological conditions in the nose and nasopharynx, such as hypertrophic rhinitis, deflected nasal septum with a spur, with marked occlusion of the nasal passage, nasal polypi, hypertrophied adenoid tissue, and nasal allergy. The treatment and removal of any upper respiratory infection, such as a submucous resection, removal of nasal polypi, and x-ray or radium therapy to the nasopharynx, or surgery to remove any excess adenoid tissue which may obstruct the eustachian tube, is of great importance.

As for local treatment to the middle ear, cleanliness is the most important factor. Powder, such as sulfathiazole or sulfadiazine, is beneficial in killing off any pathogenic organisms. If any granulation tissue or polypi are present, the removal of such tissue and cauterization of the remaining tissue with 25 per cent silver nitrate will encourage healing of the raw surface. I think it is good therapy to give any of the sulfa drugs by mouth and also to give a trial use of penicillin in normal saline as topical application to the middle ear. It will at least inhibit the growth of the pathogenic organisms.

Usually in this type of infection there may not be any evidence of granulation tissue or polypi in the area of the promontory. There may or may not be any destruction of the ossicles of the middle ear. Attic disease usually is not evident. Surgery, such as radical mastoidectomy, in this type of infection is, as a rule, not satisfactory. This type of ear, if under care, is a safe ear. The hearing usually is fair, and the ear will periodically be dry.

The second type of chronic discharging ear is most important; it is the foul, dirty, yellowish discharge with white, shiny, greasy flakes, suggestive of cholesteatoma. Examination reveals the pathology to involve the attic. The perforation is usually in the area of Shrapnell's membrane, anterior and posterior region, and can be found in central perforations direct with the attic area. It is in this type of infection we find certain clinical findings, such as extreme deafness and positive fistula test which, on pressure in the middle ear, causes dizziness and nystagmus. Headache may or may not be a symptom. Facial nerve paralysis may be a symptom. In long standing cases, perforation of the dura may cause brain abscess of the temporsphenoidal lobe, erosion into the lateral sinus causing septicemia, or erosion of the cortex causing subperiosteal abscess is not uncommon.

This type of chronic suppurative otitis media is, as a rule, one of long standing. They usually afford no discomfort to the patient other than a foul odor and the problem of keeping the ear clean. The gradual loss of hearing, plus some mild symptom, such as headache, dizziness, or slight pain, will finally result in the patient seeking medical advice. The patient who has this particular condition is not aware of the dangers he or she is carrying around. It is therefore up to every physician to inform that individual of the dangers they are exposed to. They are in the same dangerous position as a person sitting on a keg of dynamite. It may go off at any minute. We have all seen these patients come in with high temperature, stiff neck, comatose, significant of meningitis and brain abscess. Extreme dizziness, temperature and chills, significant of fistula, plus labyrinthitis, septicemia, and large subperiosteal abscess due to erosion of the cortex of the mastoid process, and facial paralysis in this type of infection is not uncommon.

What to do for this latter type of suppuration of the middle ear has always been a debatable question. First of all, there is marked hearing loss, as a rule, unless the infection is confined to the attic area alone. One may always lean to the conservative side and use sulfa drugs, penicillin subcutaneously and locally in the middle ear, burning down all granulation tissue present, and removal of all polypi, to see if the ear may not stop discharging and stay dry. It has been my experience that when there is a cholesteatoma present there is always a marked bony infection (osteomylitis) and any local treatment is of no avail.

I think we can safely say, after a thorough course of conservative treatment with no decrease in discharge, and any suggestion of the ear becoming dry, that surgical intervention is the only recourse to a cure. Let me state now when we refer to a cure we mean the removal of all diseased tissue in the middle ear and mastoid area, thus eliminating the danger to life due to complications from the infection, and preserving what hearing is left in the ear. No hope to improve the hearing is ever anticipated.

The type of surgical intervention which is most successful is the radical mastoidectomy. A thorough surgical removal of all infection in the middle ear and mastoid cavity, plus a most thorough attempt to close the eustachian tube by curetting, usually will result in a dry ear. Postoperative care is most important, to see that epithelization takes place.

Summary

1. Our aim in the treatment of chronic suppurative otitis media is to conserve hearing and prevent the patient from being exposed to complications which may result from the infectious process.

2. The evaluation of local therapy in the form of solutions or powders is convincing only when the type of the pathology is considered in the particular case.

3. Surgical intervention must be radical. Simple mastoidectomy in chronic suppurative otitis media will not arrive at a surgical cure for the infection. Simple mastoidectomies only remove the disease from the mastoid process and the middle ear still remains infected, thus cholesteatoma ingrowth continues and the result is a suppurative process.

4. Let no case of chronic suppurative otitis media go untreated. Something can always be done to clear up the infectious process.

Discussion

Robert M. Dearmin, M.D. (Indianapolis): I have enjoyed Dr. Dietl's paper and there are only a few points on which I feel I can add anything pertaining to the care of chronic mastoiditis.

He has covered the medical care in chronic suppuration, including the treatment of upper respiratory infections. The treatment of chronic sinus disease and the elimination of infection often makes it possible to obtain a dry ear where disease is confined to the middle ear and eustachian tube. We have been receiving more literature and many samples of preparations containing urea and sulfathiazole or sulfadiazine. I have used urea for some time and there is no question that it is of some benefit where the disease is confined to the middle ear. But where the disease involves the attic and antrum, with chronic bone destruction, conservative treatment of any type is usually of no avail.

Some years ago I made a statement that I could see no excuse for the so-called modified radical mastoid operation. I wish to rescind that statement. In some carefully chosen cases where there is very little or no attic and middle ear involvement, with fair hearing, and the ossicles intact, I believe the modified radical operation is indicated. However, we must start our operation mentally prepared to proceed to a complete radical if findings at operation necessitate the more radical procedure. In the modified operation the bridge is left intact. The aditus is enlarged and the skin flap is made as in the complete radical. I have had excellent results in a number of these cases in the past few years.

I also think a word of caution should be given regarding chronic middle ear infections in children. As a rule, results are not good following a radical mastoidectomy. I believe a simple mastoidectomy should first be done, followed by conservative care of the middle ear even though a future radical may be required.

As to the method of surgery I would still recommend the bur as superior to the mallet and gouge. I am sure that in this state the number of men who use this method has greatly increased.

As to the after care, I would continue to warn against the indiscriminate use of silver nitrate. It destroys extending epithelium in the mastoid cavity. I advocate the use of bismuth paste gauze which encourages a firm layer of granulations for the extension of epithelium.

And, finally, I would like to urge that we as otologists continue to spread propaganda to the general practitioner that he have something done for his patient with chronically discharging ears. We may conserve hearing, certainly will reduce morbidity, and often save life. Any one who spent a few years in the Army realizes how many people are going serenely on their way, not realizing the danger connected with chronic ear disease. They are doing this because in many instances they have not been told of their danger and they think nothing of the drainage and the odor, and all of this in the face of the fact that so much can be done for them. We can always promise them a safe ear.

TREATMENT PLAN PROPOSED FOR ROCKY MOUNTAIN SPOTTED FEVER

Rocky Mountain spotted fever, a tick-borne disease, which is often severe and sometimes fatal, is geographically scattered over 47 states. Since few physicians have the opportunity to treat many patients with this disease, a Greensboro, N. C., doctor offers a comprehensive plan of treatment applicable to every case.

Writing in the April 5 issue of *The Journal of the American Medical Association*, Samuel F. Ravenel, M.D., from the pediatric service of St. Leo's Hospital and the Sternberger Children's Hospital, suggests that treatment with para-aminobenzoic acid, one of the vitamin B complex group, will eliminate practically all deaths from this fearful disease.

Treatment of five patients with this drug, in combination with standard methods, produced "rapid" and "brilliant" results, states the author.

The dramatic effect of the drug is well illustrated by the reaction of a patient, 17, who entered St. Leo's hospital with a history of tick bite, headache, malaise, fever and chills, rash and delirium. Because one of the symptoms is dehydration, the patient received large amounts of fluid, salt in the daily diet, also vitamins and blood transfusions. Para-aminobenzoic acid was given every two hours by mouth in a solution of sodium bicarbonate.

Within 24 hours the condition of the patient improved. On the fifth day the temperature dropped sharply, reached normal on the sixth day and remained there. Also on the sixth day, the rash faded and the boy was practically well.

"In comparison with experience with Rocky Mountain spotted fever in the past," states the physician, "this was a brilliant therapeutic result in a rather severe case. Ordinarily this boy might have been expected to be extremely sick for two or three weeks."

The rickettsias, bacteria-like parasites, responsible for this disease do not respond to sulfonamide compounds. The author states that they are not only useless but probably harmful in the treatment of this disease. Moreover, he adds, "although rickettsias are reported to be sensitive to penicillin, this agent has proved useless in the treatment of Rocky Mountain spotted fever."

Reviewing the status of the disease today, the author states: "The name Rocky Mountain spotted fever is now obviously geographically incorrect, since this disease has been found in 47 of the 48 states. Ten years ago 70 per cent of the cases occurred in the Mountain and Pacific states, while 87 per cent were reported from the Central and Eastern states in 1945. Its incidence and importance to public health in the United States are shown by the occurrence of 400 to 560 cases with 90 to 137 deaths each year during the past decade."

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

CONSERVATION OF VISION AND THE SCHOOL CHILD

For the eighth consecutive year THE JOURNAL has devoted the principal portion of its text to the subject of visual conservation. It would seem appropriate that this publication should desire to emphasize to the physicians of this state not only the newer advances in medical practice but also to afford general information upon those subjects which are in the category of being not so well understood. Ophthalmology is ever a medical and sometimes a surgical problem. The basic precepts of medical and surgical teaching obtain always in the care of the visual apparatus. To care for the eyes without these basic considerations can be nothing but inadequate.

During the war years the branches of the service selecting young men for aviation training of necessity made careful and comprehensive checks upon the visual apparatus of thousands of applicants. These standards, while in some respects somewhat exacting, nevertheless had as their prime consideration a pair of well-functioning eyes. The percentage of applicants failing the examination because of this one factor was amazingly high. While in civil life we cannot desire to have our school children all possess an inherent facility of good visual efficiency, we can reasonably expect, by the employment of proper examination, advice, hygiene, and the use of corrective glasses when indicated, a much higher standard than we now enjoy. Too many of these young men did not realize their visual shortcomings.

It is obvious that the starting point for the detection of such deficiencies can best be handled in the school system. It is also obvious that the population at large is not deriving the maximum benefit which the educational system could afford to incorporate in its program. The cost of physical equipment, the training of lay personnel, and the time lost from the usual activities of the school day are not prohibitive. The co-operation of medical men trained in the specialty is undoubted. Adequate uniform methods of screening the school child at intervals of at least two years during the first eight years should not in any way overtax the schools if done in a systematic, orderly routine. The opinion of a school nurse or teacher, based on the child's performance in the schoolroom, or a Snellen rating done in an improperly lighted room, coupled with the confusion and lack of co-operation because of other schoolmates nearby, adds sufficient

variables to render their referral to an ophthalmologist valueless in too large a percentage of cases.

It is to the credit of the aviation branches of the Army and Navy that within a few months following the outbreak of war highly efficient organizations for such screening were in operation. These centers worked with specially trained medical corpsman doing the majority of the work under the supervision of but a few medical officers. It poses the question again whether some of the lessons learned during the war cannot well be applied to civil life.

OUR LEGISLATIVE COMMITTEE

For some forty or more years we have watched with much interest the presentation of bills in the biennial sessions of the Indiana General Assembly, referring to proposed legislation that directly affects the medical profession. For some years we served on this committee, under the direction of that "Master Mind," the late Dr. William Niles Wishard, Sr.

In the succeeding years we have taken a lively interest in the committees that have functioned in this capacity and are prepared to say that our present committee heads, long holding those positions, have "done themselves proud" this year. Norman Beatty and J. William Wright certainly know their way around the legislative halls, though of course little of their work is done at the State House.

Through a long service they have come to know personally many of the old-timers in legislative affairs, as well as to strike up many intimate acquaintanceships with doctors all over the state.

They long ago learned just whom they could depend upon for factual information from all quarters of Indiana, knew just whom to call upon when some emergency arose and, best of all, knew just what to do with that information when they got it.

Another factor was of very great importance, the presence of Ray Smith. Ray had long been an "inmate" of the Hoosier Capitol and had good training in legislative matters. He was able to "get to" the Republicans as well as the Democrats —could, and did, talk to all of them.

The accomplishments of the committee, this year, were many; in fact, it is our opinion that Indiana Medicine fared better than in previous years. To us, the standout feature was the handling of the Chiropractic Bill. This we regard as one of the most dangerous measures they ever have presented; its passage, and enactment into a law, would have broken down many of the safeguards we have erected through the years.

When two definite attempts were made to "blast" the bill out of committee, the vote was astoundingly in favor of sane and sensible consideration of all health matters. Following the second failure the "chiros" threw in the sponge, but it is said they have announced they will be back again, in 1949.

Probably the greatest efforts were directed toward opposing the chiropractic measure, but there were numerous other matters that held the attention of the Legislative Committee. This committee, of course, was not in favor of increasing the annual registration fee over that provided in the original measure, but wisely agreed that there are times when discretion should be used. The House Reference Committee felt that we should pay the same fee as other professional registrants, which idea put it squarely before the medical committee. They had been directed by our own House of Delegates to make every effort to have the measure passed and a fight over the matter of the registration fee might have scrapped the entire program.

Through several decades we have watched our Legislative Committees during the biennial session and are prepared to state that the 1947 "campaign" was tops.

OLIN WEST RESIGNS

Announcement has been made of the resignation of Dr. Olin West, as president-elect of the American Medical Association. Dr. Edward L. Bortz, vice-president, of Philadelphia, succeeds to the post.

In his letter to the Board of Trustees Doctor West states that ill health will prevent his attention to the duties that would evolve on him during the coming year.

It has been known for some time that Doctor West has not been in the best of health and that he was unable to attend many functions usually looked after by the president-elect. Last October he was to have been the banquet speaker at our Indianapolis session, but was unable to be present.

For many years, more than two decades, he has served as secretary-general manager of the American Medical Association. Prior to that time he was engaged in many medical organization activities, among them acting as secretary-editor in his home state of Tennessee.

Through these long years of service he has been a hard worker, all too often refusing to have some assistants appointed—he wanted things done *his* way, therefore he would do them himself.

To one not intimately acquainted with what goes on at 535 North Dearborn Street, Chicago, the enormity of the task of secretary-general manager means little. Either post would be a man's job in itself, so when one man takes over the two jobs he has something on his hands.

For a good many years past the close friends of Olin West have urged him to slow down and get some "Georges" to do the heavy footwork. We recall an instance related by a former A.M.A. official, in which he stated that on one occasion he took Doctor West up to the board room, *locked the door*, and "gave him plenty of H——!" But, so the official told us, "It did not do a bit of good; he

promised to accept some help but just never got around to it."

Doctor West did a big job for organized medicine and did it well, and it is to be regretted that he finds himself unable to end his medical career at the helm of the greatest medical organization in the world. His friends are legion and they all unite in wishing that in years to come he may be sufficiently restored to health as to be able to enjoy the fruits of his long years of labor in a most worthy field.

ANNUAL REGISTRATION

For a good many years a large number of our members have talked in favor of an annual registration law for all practitioners of the healing art; the matter has been discussed in the House of Delegates over a period of several years but not until the 1945 session did the House vote in favor of the presentation of such a bill to the 1947 General Assembly.

The bill passed both Houses, was signed by Governor Gates, and is now the law, there having been attached thereto an emergency clause.

Our information is that the Medical Board has held a meeting to discuss the new law and has had a representative visit other State Boards where the annual registration is in effect, there to make a study of the various plans and to report back to a future meeting of our board.

This new law covers all who practice any phase of the "healing art," which means that the drugless licensees will also pay the annual registration fee.

Much has been said over the years re the enforcement of our Medical Practice Act; many suggestions have been offered as to how this could best be brought about. But there always has been the same "bottle neck," where to get the money to hire competent investigators.

This new law provides that the State Budget Committee shall appropriate from the funds collected the amount needed by the board to properly "police" the state. There is little doubt but that the registration fees will more than cover this amount, any balance reverting to the state treasury.

A little fly in the ointment, however, comes from the fact that the legislative committee to which the bill was referred "raised the ante." The original bill called for an annual registration fee of two dollars; this the committee raised to five dollars. We rather expected this, from the fact that all other professional registration fees, with one possible exception, provided for a fee of at least five dollars.

There are some repercussions over this provision, but the fact remains that this is the law and there is little we can do about it. There still are those of our profession who maintain that the enforcement of the law is the duty of the state, that private citizens should not be assessed for such purposes. On the other hand, it might be said that the medical profession, here in Indiana, is ever "health minded"; that we always are on the lookout for anything that will tend to maintain the health of our people.

There is another interesting phase in this matter; there is little doubt in the minds of those experienced in State Medical Board matters that there are some engaged in the practice of the healing arts who have no licenses so to do. We recall several investigations we personally made during the time we served on the board, uncovering several fraudulent practices.

The net result is that we asked for a registration law and got it; perhaps not exactly as some of us wished to have it, but nevertheless a law with plenty of teeth in it and apparently plenty of funds for its enforcement. The board plans to notify every practitioner, at a date in the near future, as to the plan for registration and THE JOURNAL will keep in active touch with the board and from time to time publish such information as is available. It is hoped that in a short time we may have an official communication from the board, giving full details, and we recommend that every one of our members reply to board letters, immediately.

SPRING TONICS

A goodly number of the old-timers in Hoosier Medicine recall the magic of the words, "Spring Tonic!" Particularly in the rural areas did the folk begin to look about for the ingredients of their favorite mixture, and city folk, who had been reared in the country areas, commonly did the same thing.

Common belief was that the winter months had "thickened the blood" and that some remedy, or remedies, were needed along about the time Jack Frost began to take his departure. As a preliminary treatment, most youngsters got a daily dose of New Orleans molasses, with sulphur, this for a varying period. As we recall, the mixture was *not* the most delightful concoction in our memory; in fact, we definitely did not like the stuff, but, perforce, we took our daily ration.

After this preliminary toning up of the system it was deemed advisable to "thin the blood," and in all Hoosierdom nothing was more efficacious for this purpose than "Sassafras Tea." So it was that the menfolk in our community went into the hills of Wild Cat and dug the roots of this aromatic tree—we called them shrubs in those days. The bark was carefully removed from the roots and from this the tea was made. Even today, probably from force of habit, along about the first of April of each year we scan the local market for sassafras and find that it has a ready sale among those who know.

Our attention to this subject was directed by an article, "Sassafras," in the April, 1947, number of

Natural History, official publication of the American Museum of Natural History. The author, Betty Wilson Higginbotham, calls it "A sixteenth century penicillin and sulfanilamide rolled into one." She also recalls that, years ago, it was introduced into disease-ridden Europe where it soon came to be regarded almost as a panacea.

John Gerard, in a booklet published in 1597, gave minute directions for preparing the tea, recommending it for "dropsie, oppilation or stopping of the liver, quotidian and tertian agues, and for long fevers. It provoketh urine, removeth the impedimentas that do cause barrenness, and maketh women to conceave."

We once saw a list of diseases supposed to be cured by proper use of sassafras tea, a veritable compendium of the things that ail the human race. At one time it was announced that syphilis would bow to this treatment, whereupon sassafras became in such demand that difficulty was found in supplying the market.

It is believed that the American Indian first learned of sassafras tea and that the French Huguenots, on their trips to Florida, learned of it and took a supply back to Europe. Sir Walter Raleigh is said to have taken large quantities back to England where he sold it at the rate of $4.00 per pound.

Sassafras is native to most of Indiana and in early spring it is not uncommon to find folk digging at the roots of certain trees; to the initiated this means that they are getting sassafras roots. It is a pleasure to us, after all these years, to find one of our leading Nature Magazine giving full space to the virtues of a root whose acquaintance we made many decades ago.

Editorial Notes

THE JOURNAL is indebted to Dr. E. W. Dyar, of Indianapolis, for his work in collecting material for the special Conservation of Vision number. Each year we appoint some member to supervise this particular number and in recent years have given him *carte blanche*—he just goes ahead, makes his own plans, not overlooking the aid of others whom he consults, and, as in the present instance, comes up with a bang-up number. This year we were especially pleased to note the discussion of contact lenses, as well as the use of penicillin in eye treatment; both of these subjects are relatively new and have been handled in a most excellent manner. We also were very much interested in the article on industrial ophthalmology, the writers having presented one of the best discussions of this subject that has come to our attention. Again we say, "Thanks, Doctor Dyar, for a good job, well done!"

The vinegar market up around South Whitley probably is again "upped," due to the fact that the "Kaadt Diabetic Institute" is again in operation, this by grace of the local circuit judge, who overruled the Medical Board. However, it has been decided to appeal this case to the Indiana Supreme Court, the decision of which will be read with the greatest of interest by all members of our profession.

Reports are to the effect that the one hundredth anniversary meeting of the American Medical Association, in Atlantic City, will show the largest registration in history. We are advised that hotel reservations still are to be had but that prompt action will be necessary to obtain one. If you are planning to be there and have not yet made your reservation we would suggest that you take the matter up with Ray Smith, at headquarters.

The Association of Interns and Medical Students is much concerned with a resolution introduced in the December meeting of the A.M.A. House of Delegates concerning the salaries of interns. The resolution calls for "a reasonable and maximum figure for the remuneration of interns and residents," setting forth that some hospitals in which the teaching facilities are not of the highest order *might*, in order to attract interns, pay a higher salary than others. The matter was referred to the Council on Hospital and Medical Education and their recommendations no doubt will be presented to the House, at Atlantic City. There can be no argument against the payment of a fair salary to these hospital necessities and it is hoped that the final action in the matter will be satisfactory to all concerned.

The "eye bank" program seems to be going along nicely, the latest "bank" to come to our attention being organized at the Massachusetts Eye and Ear Infirmary, in Boston. It is presumed that this will be operated under the general plans set forth by the Eye Bank Foundation, with headquarters in New York. The Foundation is well organized, seemingly headed by the right sort of officials to make it the success it should be. Not only do they establish "banks," but they also have a training course set up for those chosen to take up the study of the technique of this unusual operation. It is estimated that there are a quarter of a million blind persons in this country, some fifteen thousand of whom have corneal opacities of one sort or another which are the cause of the blindness. In many of these cases a corneal graft, expertly done, will restore some degree of vision. We are pleased to note the reception ophthalmologists, generally, are giving the new venture.

President's Page

COMMENDATIONS

EVERY physician in Indiana owes a debt of sincere gratitude to your state Legislative Committee for its outstanding work during the recent session of the General Assembly. Write to them, personally. Or, when meeting them, let the warmth of your handclasp convey to them your heartiest thanks. The final score was heavily in our favor. Our association sponsored bills, annual registration *(S.B. 213)* and the amendment to the licensure act *(S.B. 212)*, passed 67 to 0 and 66 to 1, respectively. This was excellent, almost perfect. Two motions to bring the chiropractic bill out of committee for discussion and action in the House were lost, 68 to 15 and 51 to 12. This was good but could and should and must be improved. It can be done.

The battle over the chiropractic bill waxed very bitter at times, odds seemed weighted against us; but, when the chips were down, the letters and telegrams from the county societies, from their legislative committees, and from individual members to their representatives proved effective. Commendations to all who so unselfishly responded.

As per usual, further experience was gained, and a few weak links again were obvious. Most important among these latter is one which needs close attention in the future. It is this: Session after session certain counties regularly send to both branches of the General Assembly representatives who are friendly to our profession and staunch advocates of sound medical legislation, men who are outspoken against measures which, if passed, would undermine good medical care for the citizenry of our great state. On the other hand, there still remain a few counties which biannum after biannum pay no heed to this important matter. Why? Your answer is correct. You have the diagnosis and know how to apply the necessary treatment. If not, if consultation is worthwhile, see or hear me at your

DISTRICT MEETINGS

May is the month. Your society picks the date and designates the hour. Within the limits of time and physical ability, I hope to meet and see and talk with as many of you as humanly possible. Numerically and in every other way our organized strength is growing—ever and ever stronger. And, by that very token, our obligations to the public become ever and ever more numerous and more ramifying. Let us measure up to the leadership expected from us.

COMMITTEE ACTIVITIES

Your Council and its Executive Committee have been meeting regularly for the transaction of your association business and for attention to its many affairs.

The Veteran's Committee meets every month under the able leadership of Dr. Charles F. Thompson.

Dr. O. A. Province's committee on Scientific Work, along with the Section officers, are busy in preparation of the program for the French Lick session in October. Lend them your help if called.

A Committee on Instructional Courses has been appointed, Drs. Sage and Batman being named co-chairmen. See the roster in this issue. It's a live committee.

DELEGATES

"The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before June first" . . . By-laws. Choose them with care. Send your best. May they be properly instructed on the wishes of your society, and duly impressed with the necessity of being present to participate in every activity of the House of Delegates at each and every session. That is democracy at work.

Sincerely,

Floyd T. Romberger

PUBLIC RELATIONS*

J. S. DE TAR, M.D.†

MILAN, MICHIGAN

IN Michigan we have been attempting to do a job for the past three years, a job along the line of public relations, and it is a pleasure to come down to Indiana and talk to you about it. I may be bringing "coals to Newcastle," because Indiana certainly has provided the national medical picture with many leaders. I am thinking particularly of the field of rural health, and the associated physicians and surgeons group, and I am thinking of the work that has come out of Lake County, under Mr. Rollis Weesner, in connection with the bulletin called "The Ounce of Prevention," which is something we are going to try to copy in Michigan.

We have been working on this matter for the past three years; we have made mistakes; we have spent a lot of money; and if you can profit by our mistakes I will feel I have done something. We feel that the basic philosophy underlying the consideration of a need for a public relations program seems to embody two main tenets: one positive, one negative. First, on the positive, that American Medicine is supplying the American people with good medical care, that it has been stimulated by a system of free enterprise and that we are now engaged on a nation-wide scale in an effort to provide to all the people an insurance plan to cover their needs. On the negative side there is the thesis that no government system of politically-controlled medical care has been proposed which does not involve danger to the people. In those two fields we must carry on an educational program for the laymen. The negative approach will keep American medicine on the defensive. But to carry on a comprehensive program of public education of the laymen will certainly aid in eliminating the oft-repeated accusation that the doctors never lead the way, but acquiesce only when the force of pressure becomes irresistible. In Michigan, as in Indiana, we have recognized the need, and we are trying to do something about it. There is very little experience on which to go. We have certainly made some mistakes. Perhaps a little resumé of some of the things we have been trying to do may be of help.

Back in 1944 we felt the need for improving our public relations with the laymen. Therefore we levied a general assessment, passed by the House of Delegates, of $10.00 per member. With this money we conducted a state-wide survey through one of the polling institutes, to find out how the layman felt about the doctor, about voluntary and government insurance. We discovered that whereas a majority of all the people felt they were getting good medical care, some felt that the care was not adequate, that some of the doctors could not be trusted, that there was some overcharging. The majority seemed to feel that we needed some form of insurance to assist people of low income in paying their hospital and medical bills. The majority seemed to favor a system sponsored by the profession.

In 1946 we felt that we should really do something about lay education. A special assessment was levied of $25.00 per member, for the purpose of carrying on a public relations plan. This was accepted by the profession and gave us a fund of $108,000 to spend last year. The first thing we did was to employ a full-time public relations counsel, a man who had some experience in the newspaper, radio, and advertising field. We felt that was necessary, because although we have a good man as executive secretary of our society [and I understand that Indiana has Mr. Smith and Mr. Palmer, who have had extensive experience in the newspaper field], still we found that our executive staff was so overburdened with work that the whole field of public relations was receiving inadequate care. Back in 1944 the whole plan which we are now carrying was proposed and the council tabled it for lack of time and help. Apparently, in order to improve the public relations in any state medical association it is necessary to have first, the funds; and second, to employ a man who gives his full time and attention to it.

Next, we enlarged our state Public Relations Committee, from a membership of eight or nine men to thirty, to include one man from each councilor district, in addition to representatives of the Radio Committee, the Scientific Radio Committee, a committee for development of literature, a committee to distribute literature. We have a large committee now and it is functioning fairly well. This committee then met and decided on a policy; the policy was then presented to the entire state medical society, in the form of a sixty-page brochure. They were asked to read it and bring it to the last House of Delegates meeting. Then they voted it in. Now we have the man, the money, and the plan.

We feel that the essence of good public relations in the end does not come from the A.M.A. or from the state society; it is the individual relationship of the doctor with his patient. The question is how to arouse the doctor from his self-satisfied lethargy and his complacency with the status quo; how to help *him* improve *his* public relations. We hit upon the idea of publishing pamphlets. Our committee got to work and gave us pamphlets

* Presented before the Secretaries' Conference, in Indianapolis, on January 12, 1947.

† Speaker, House of Delegates, Michigan State Medical Society.

which were then sent out to every member of the state society, with the request that he hand them to his patients. They had fairly good acceptance; on the other hand, they didn't reach all the public. One of the doctors in Detroit went through every office in his building and didn't find one pamphlet, yet a card sent out to the doctors brought the response from 80 per cent of those replying that they were using their pamphlets and wanted more of them. These pamphlets do not satisfy all of the doctors, and if you launch a program which pleases all of the doctors, you will have something. The pamphlets are written in laymen's language; they use the cartoon principle; they don't appeal to college professors, and they don't appeal to all doctors, but they are understandable. A butcher stopped a doctor on the street and said, "I am glad to see that you fellows got down to our level." We feel they are doing some good. We have distributed several hundred thousands of them. They cover advances made in the field of medicine, et cetera. We are allocating $10,000 for that purpose.

In the field of newspaper advertising, we felt that when the Wagner-Murray-Dingell bill was in committee, something should be done to tell the people about it, so the state society appropriated $4,500 out of last year's budget for one advertisement in each of the eighty papers in the state. A request went out to the county societies, saying, "If you are in favor of this idea you may have eleven of these ads if you will pay for their insertion." In a great many places they were inserted, in some cases by individual doctors. The state society, for $4,500, had $50,000 worth of advertising placed in state papers. This was dignified advertising. We felt it did some good. On the other hand, we felt that the societies and physicians who paid for those advertisements will not feel like putting more money into a project for which they are already being assessed $25.00 yearly, so we have $30,000 in our budget this year for newspaper advertising. We have eighteen advertisements which are going to be spaced about every two weeks or so, and $30,000 is going to cover it. We didn't have to write these ads. We employed an advertising agency in Grand Rapids, which is writing the ads. There is no extra cost in employing a newspaper advertising agency, because that cost is all considered when a newspaper takes your advertisement. Thirty thousand dollars is less than we spent last year, and it is doing much good.

Concerning magazine advertising, we inserted twelve ads in the *Michigan Farmer*. We are planning on advertising in labor magazines this year. We feel that every means of getting to the public must be used if we are going to do our job.

We made some mistakes in radio. For two years we spent large amounts, a thousand dollars a broadcast, over eighteen stations in Michigan; it cost us quite a lot of money. We were paying for an agency to put on the show and we were paying for the time. We don't feel we have accomplished a great deal. It is difficult to compete with the entertainment programs on the radio. This year we changed our tactics. We are on the radio five days a week all during the year, something like three hundred and twelve broadcasts, in five-minute news programs. These are staged by a top N.B.C. broadcaster. He does them very well. They are put on records. These records are sent to the eighteen stations in Michigan; three and one-half minute broadcasts, allowing the station to sell them to some commercial interest in the local community, which must be approved by us, so that he can say something before and after the broadcast. They are strictly up-to-the-minute news broadcasts concerning both scientific and socio-economic health news—anything which is new. This program is costing us $14,500 this year, compared with $30,000 on the other program last year. We are getting on the radio daily instead of once a week. We feel that the program is much more effective and it is possible, in a program such as this, to say something about voluntary insurance coverage, about the good job the doctors are doing in medical coverage, and something about government insurance; the Federal Communications prevents your discussing in very strong terms something which is controversial, but we do feel this program is working out well. These transcriptions are costing us $14,500, but the time is costing nothing. The radio station or sponsor is paying for that. We estimate that we are getting $100,000 worth of time this year, without cost.

Incidentally, these same transcriptions will be available to any of the neighboring states. If any states feel they want to use that type of program, they will be available at cost, perhaps $2.00 a transcription record. This same broadcast is being put on mat form for distribution to weekly newspapers throughout Michigan as a health news column, and four hundred newspapers are receiving this up-to-the-minute medical news at no cost. We feel that we are getting much better contact with the layman.

We have a scientific radio program staged by the teaching personnel of our medical schools, which is being broadcast weekly over the stations through Michigan, at no cost.

Concerning another phase of the program—in the city schools in Detroit plans are being laid for presentation of medical programs in every city high school and in the grade schools. The cost will be slight on this. It consists of transcriptions, and one of the large universities is giving its time and talent, in its speech and radio classes, in the making of these dramatizations. This program would never have been possible if we had not first raised the money and then hired a full-time man to supervise it.

Concerning the Speakers Bureau, I notice you are very active in this line. Our Speakers Bureaus are not centralized in the state medical society. We have a Speakers Bureau in each county

society under the Public Relations Committee. We do not have a state committee completely responsible, as each county runs its own Speakers Bureau. We find it is more effective because when requests come to our state office, we don't have to send a man, at great expense, two or three hundred miles, but can call on some man in that area. They have all been provided with speaker's kits, and we do have a large body of men trained. In order to keep our men informed, we are sending from the state committee a monthly bulletin to the public relations chairman in each county, asking him to get up in his monthly meeting and tell the men what is going on and what is expected of them. We have hundreds of requests for debaters kits which we prepared for high school debates. As you know, the subject over the nation has been "Voluntary versus Compulsory Medical Insurance." The kits included much pertinent information, and we have had tremendous requests for them. It all costs, but the money is well spent.

In summary, gentlemen, we are still experimenting. We have not traveled as far as we have without difficulty. We have had very much criticism. Criticism was made in the last meeting of the House of Delegates, with a ten-page brochure telling what a poor job we were doing. But the House of Delegates decided to assess another $25.00 this year. Incidentally, we are not spending the whole $100,000 each year; we saved $30,000 last year, $25,000 this year, for the time when we must put out a great deal of effort in a short period of time. We feel that Michigan and California are going to be used by certain organizations as experimental grounds in attempting to amend the state constitution to provide for compulsory medical insurance for workers. We feel we must have some money on hand. We don't know that we are on the right track, but if there is anything we have done that Indiana can use, we will be glad to help out.

Thank you for this opportunity of talking to you; it has been a great pleasure.

THE GREEN FAMILY COMPLETES A CENTURY OF MEDICAL SERVICE IN RUSH COUNTY

FRANK H. GREEN, JR., M. D.

RUSHVILLE

THE Green family completed one hundred years of medical service in Rush County last year. Since June, 1846, four generations of medical doctors have been in continuous practice.

The first Doctor Green licensed to practice medicine in Rush County was James Wilkinson Green, who entered the profession in 1846. Dr. James Green was a charter member of the Rush County Medical Society and its president for many years. His son, Lot Green, graduated from the Butler Medical School of Indiana, in 1881, and practiced first in Arlington, Rush County, and later in Rushville. For many years he practiced medicine in Rushville in partnership with his son, Dr. Frank H. Green, Sr., who graduated from the University of Indianapolis Medical College, in 1897. Another son, Dr. Charles Sumner Green, joined the partnership after graduating from the University of Indiana School of Dentistry. At present, Dr. Charles Green and his son, Dr. Frank H. Green, Jr., and a cousin, Dr. Lowell M. Green, are in active practice.

The dates of active practice for each generation are as follows:

Dr. James Wilkinson Green, 1846 until 1896 (50 years of practice).

Dr. Lot Green, 1881 until 1905 (24 years of practice).

Dr. Frank H. Green, Sr., 1897 until 1940 (43 years of practice).

Dr. Frank H. Green, Jr., 1932 ——?

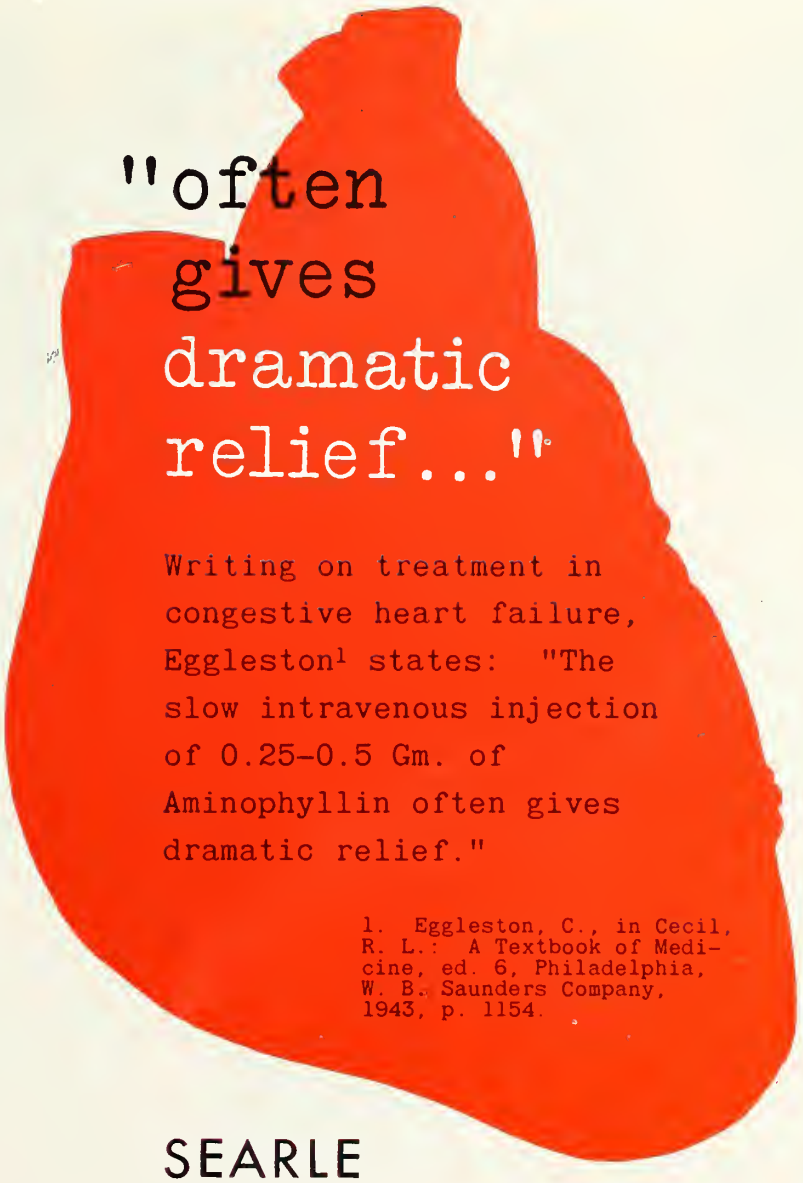
Dr. Lowell M. Green, 1906 ——?

The two-story, brick office building opposite the Court House in Rushville was constructed by Dr. Lot Green and has been used for three generations of medical doctors. Dr. Frank H. Green, Sr., specialized in surgery, and following his discharge from the armed forces of World War I had the second floor of this building converted into a private hospital for the care of his surgical patients. This hospital was closed in World War II, but the offices on the first floor are now used by Dr. Charles Green and Dr. Frank H. Green, Jr. The medical diplomas of each of the four generations are framed and hanging in these offices.

The contribution made by this family to Indiana medicine has been extensive, as fourteen doctors in four generations have been licensed physicians. All have chosen to practice in Indiana. In one case, six of seven sons were medical doctors.

The first brothers to practice were Dr. James Wilkinson Green and Dr. William Frame Green. Dr. James Wilkinson Green remained in Rush County while Dr. William Frame Green moved to Shelbyville where he enjoyed a wide and lucrative practice. Their sister Louisa married Erastus Bussell, M.D., a widely-known physician at Arlington.

Dr. William Frame Green began the study of medicine in the offices of Drs. Selman and Bussell, in Shelbyville. He later attended Rush Medi-



"often gives dramatic relief..."

Writing on treatment in congestive heart failure, Eggleston[1] states: "The slow intravenous injection of 0.25–0.5 Gm. of Aminophyllin often gives dramatic relief."

1. Eggleston, C., in Cecil, R. L.: A Textbook of Medicine, ed. 6, Philadelphia, W. B. Saunders Company, 1943, p. 1154.

SEARLE

AMINOPHYLLIN*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

—produces myocardial stimulation and increased cardiac output, together with desired diuresis. Whether administered orally or parenterally, it has a field of therapeutic usefulness covering congestive heart failure.

Searle Aminophyllin is now widely used also for its favorable effects on bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

G. D. Searle & Co., Chicago 80, Illinois.

SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

*Searle Aminophyllin contains at least 80% of anhydrous theophyllin.



James Wilkinson Green, M.D. Date of Practice 1846-1896



Lot Green, M.D. Date of Practice 1881-1905



Frank Hays Green, M.D. Date of Practice 1897-1940



Frank Harold Green, M.D. Date of Practice 1932-

cal College, in Chicago, and received his diploma from there in 1856. The first attempt at organizing a Shelby County Medical Society, in Shelbyville, was in 1868. Doctor Green was a charter member of the society and its first president. He took an active part in its activities during his thirty-four years of practice in Shelbyville.

Dr. James Wilkinson Green was first licensed to practice his profession by the Fifth District Medical Institute, in 1846. He later took additional training at the Rush Medical College, in Chicago, and received a medical diploma from there. He had seven sons, six of whom were medical doctors. Their names and the site of practice is as follows:

Dr. Lot Green practiced in Rush County and Rushville.

Dr. Preston S. Green practiced in Arlington.

Dr. John Green practiced in Manilla.

Dr. Will Green practiced in Cambridge City and Shelbyville.

Dr. Tom Green practiced in Shelbyville.

Dr. James C. Green practiced in Arlington.

An interest in medicine has been inherited by other members of the family. Alpheus Green, M.D., son of Samuel Green, and nephew of Dr. James Green and Dr. William Frame Green, practiced in Knightstown. Descendants in active practice today are Lowell M. Green, M.D., Frank H. Green, M.D., Charles S. Green, D.D.S., all of Rushville, and Harrison Green, M.D., of Indianapolis. Marvin Norris, of Rushville, is attending the University of Indiana Medical School.

The Green Family's contribution to Indiana medicine is truly worthy of note.

VOICE OF MEDICINE

OBSTETRICS IN KOREA

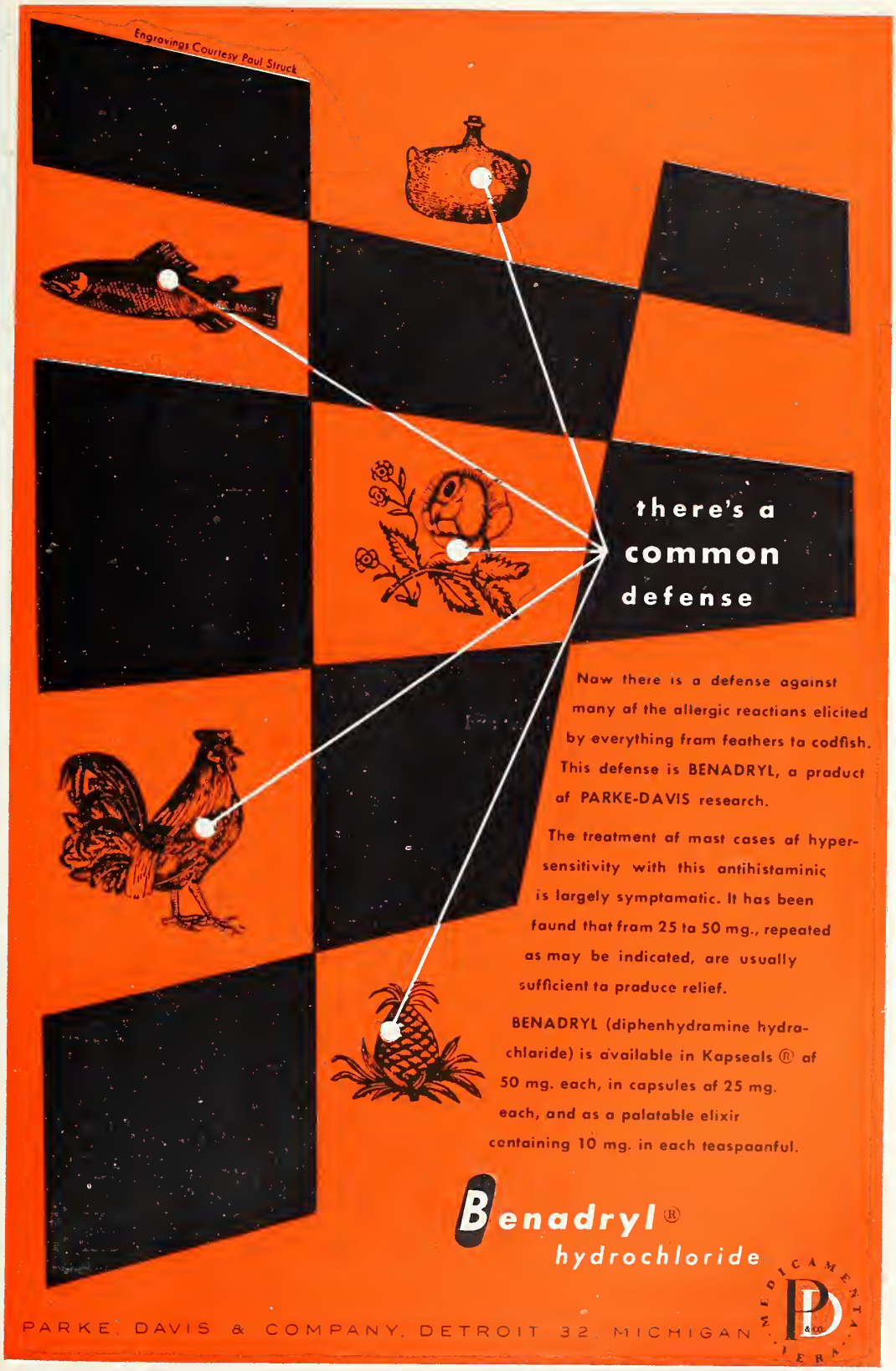
Lieutenant W. J. Schecter, formerly obstetrical resident at the Indiana University Medical Center, and now serving in the United States Army in Korea, recently wrote one of his former staffmen as follows:

"My OB and GYN practice increases as a geometrical progression. My obstetrical armamentarium, such as it is, and ingenuity are challenged every day. To date my complications include placenta praevia marginalis, renal lithiasis, pyelitis, essential hypertensive toxemia, hyperemesis, malaria, confluent vaginal and perineal condylomata, gonorrhea, borderline pelvis in an elderly primip, ascaris and hookworm infestation, and 3 ectopics. You might reasonably inquire if I have any nice, normal patients. I do have, but they are an overwhelmed minority.

"My only available analgesia are morphine, scopalamine and the barbiturates. I should like very much to introduce rectal ether in Korea, to the Korean obstetricians as well as in the army hospitals, but I don't know where or how to obtain your apparatus or the drugs. If you can give me that information, you will be doing all of us a great and appreciated service.

"In addition to my work I have had time to do considerable reading and studying, so that I am sure my time in the army will not be a total loss. The best Korean OB men are 5 years behind and greatly appreciate what little new information I can give them. I have established liaison with the obstetricians of the Imperial Medical Center and have arranged to dissect a female cadaver as soon as the weather improves.

"The vast majority of deliveries are done in the home with the aid of a midwife, who has occasionally had training. Even in the hospitals midwives do all but the most complicated deliveries. No pretense at sterile technic is made. The decision between section or craniotomy frequently rests on the availability of linens. The hospitals are unheated, and the patient's food must be brought in by the family. No analgesia is used. The only acceptable practice is done by a few European-trained men at the University. I do all I can but it's just a drop in a colossal reservoir.


Engravings Courtesy Paul Struck
there's a
common
defense
Now there is a defense against many of the allergic reactians elicited by everything fram feathers ta codfish. This defense is BENADRYL, a praduct af PARKE-DAVIS research.
The treatment af mast cases af hypersensitivity with this antihistaminic is largely symptamatic. It has been faund that fram 25 ta 50 mg., repeated as may be indicated, are usually sufficient ta praduce relief.
BENADRYL (diphenhydramine hydrachloride) is available in Kapseals ® af 50 mg. each, in capsules af 25 mg. each, and as a palatable elixir containing 10 mg. in each teaspaanful.
Benadryl ®
hydrochloride
PARKE, DAVIS & COMPANY, DETROIT 32, MICHIGAN
MEDICAMENTA VERA

Medical Panorama by the Associate Editor

CONNECTICUT reports its satisfaction with private medical insurance coverage and indicates a 10 per cent coverage of its population. "These contracts have given general satisfaction alike to the patient, the physician, the employer, and the hospital."

———ISMA———

RHODE ISLAND reviews deaths in the United States in 1945. Fewer deaths than two preceding years. Decline in deaths from major infectious diseases to a new low. Tuberculosis deaths declining. Heart disease, cancer, and intracranial lesions continue to lead. Motor vehicle accidental deaths 28,000 out of 95,918 caused by accidents.

———ISMA———

ALABAMA reports a new law for the examining, licensing and regulating of practical nurses. Hope is thus expressed to standardize and implement nursing care on the secondary level and provide adequate care for the chronic, convalescent and aged. An important feature is that "the responsibility for the administration of the law is delegated to the Nurses' Board of Examiners and Registration and an Advisory Council." Such a pioneering effort will undoubtedly find other states adopting similar measures.

———ISMA———

MEDICAL ANNALS of the District of Columbia cites an interesting exposé of "The Happy Life of an Executive Secretary," by the Observer. Quoting from an article by Henry Clepper of the Society of American Foresters: "I cannot think of any class of worker whose lives are more likely to be frittered away by detail than secretaries of professional societies—if they permit it. During a single day a secretary may be expected to display the sympathetic understanding of a father-confessor, the diplomacy of an embassy attaché, the business acumen of a wholesale merchant, the salesmanship of a used-car dealer, the financial judgment of a stockbroker, and the information of a radio quiz expert. In between times he dictates letters, signs checks, reads manuscripts, writes reports, talks to callers, keeps appointments, answers questions, gives advice, receives advice, laughs at funny and unfunny stories, shakes hands—and loves it. Often his really productive work may be done after office hours, usually at home." We always thought they should be nicknamed "Duz"; you know, "Duz does everything."

KENT COUNTY (Michigan) invites residents and interns in their hospitals to prepare papers on scientific subjects of their own choosing. A committee of judges will pick three for presentation at a meeting to be known as Residents Night. Cash awards will be given the successful contestants.

———ISMA———

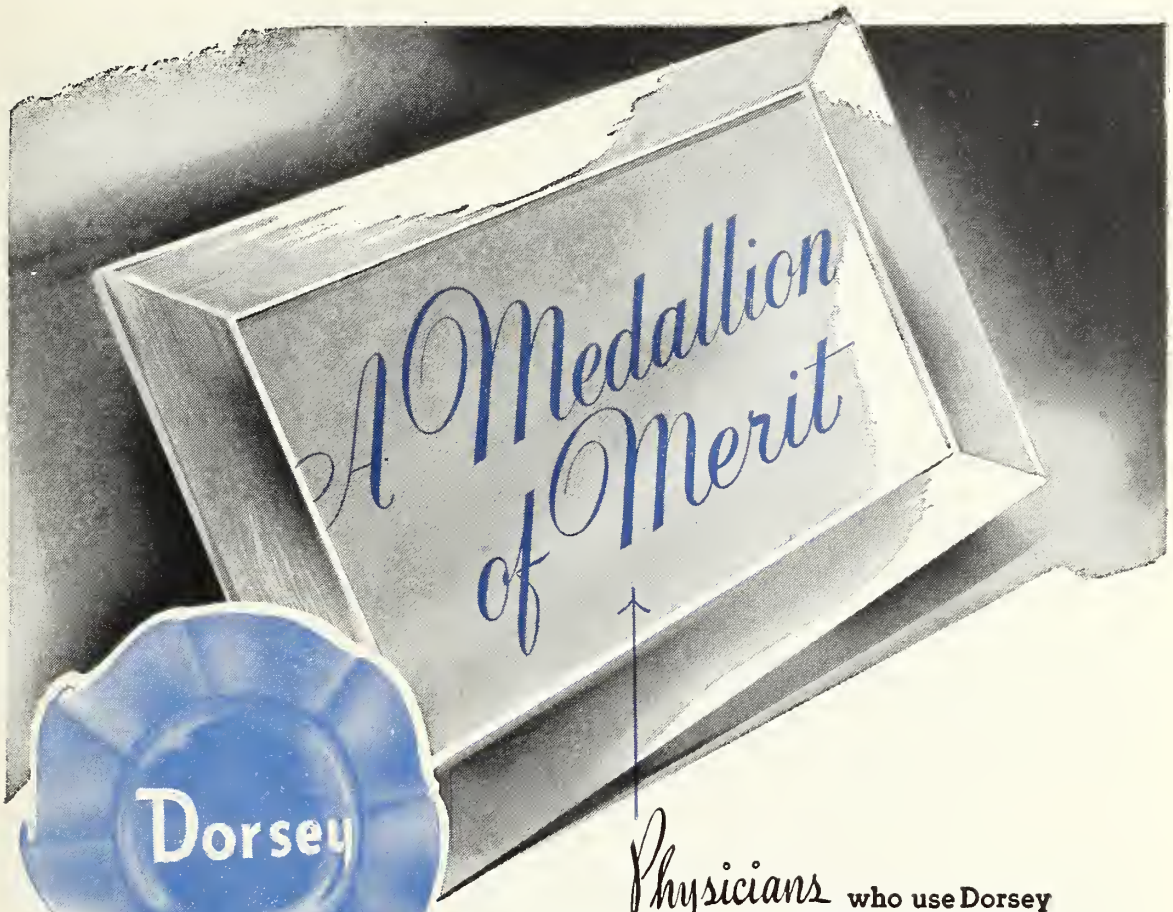
WEST VIRGINIA reports that the Governor of South Carolina seeks to require graduates of the medical college to serve compulsory two-year internships in various state institutions. Plan is based on the idea of repayment to the state for aid in professional education.

———ISMA———

OKLAHOMA recently completed a survey of state medical dues.

	Dues			Assessment		
State	1945	1946	1947	1945	1946	1947
Alabama	5.00	5.00	5.00	----	----	----
Arizona	30.00	30.00	30.00	----	----	----
Arkansas	5.00	5.00	5.00	----	----	----
California	20.00	100.00	100.00	----	----	----
Colorado	18.00	18.00	50.00	----	----	?
Connecticut	20.00	20.00	?	----	----	?
Georgia	7.00	7.00	7.00	----	----	----
Idaho	12.00	12.00	12.00	----	----	10.00
Illinois	8.00	8.00	10.00	----	----	?
Indiana	10.00	10.00	15.00	5.00	5.00	----
Iowa	10.00	10.00	15.00	----	----	----
Kansas	15.00	15.00	15.00	----	----	----
Kentucky	5.00	15.00	?	----	----	----
Louisiana	25.00	25.00	25.00	----	----	----
Maine	12.00	12.00	35.00	----	----	----
Wash., D. C.	30.00	30.00	?	----	----	?
Michigan	12.00	12.00	?	10.00	25.00	?
Minnesota	20.00	20.00	20.00	----	----	----
Mississippi	5.00	5.00	5.00	----	----	----
Missouri	8.00	8.00	8.00	7.00	7.00	7.00
Nebraska	15.00	15.00	15.00	----	----	----
New Hampshire	6.00	6.00	10.00	----	----	----
New Jersey	22.00	20.00	25.00	----	----	----
New Mexico	10.00	10.00	20.00	----	----	----
New York	10.00	10.00	10.00	----	----	----
North Dakota	35.00	35.00	35.00	----	----	----
Ohio	7.00	7.00	15.00	----	----	----
Oklahoma	12.00	12.00	22.00	----	25.00	----
Oregon	20.00	20.00	?	10.00	10.00	10.00
Pennsylvania	20.00	20.00	?	----	----	----
Rhode Island	25.00	25.00	?	----	----	?
South Dakota	15.00	15.00	50.00	----	----	----
Tennessee	6.00	15.00	15.00	----	----	----
Texas	20.00	20.00	20.00	----	----	----
Utah	15.00	15.00	50.00	----	----	----
Vermont	20.00	20.00	35.00	----	----	----
Virginia	7.00	7.00	?	2.00	2.00	?
Washington	20.00	20.00	25.00	----	----	----
West Virginia	10.00	15.00	15.00	5.00	----	----
Wisconsin	33.00	33.00	?	----	----	?
Wyoming	7.50	7.50	25.00	----	----	----

? Indicates figures not yet decided upon by meeting of House of Delegates.



Physicians who use Dorsey pharmaceuticals—and continue to use them—are granting us the highest possible award: their confidence.

Confidence—the Medallion of Merit awarded by our friends—binds us more closely than ever to high manufacturing standards. For continued confidence must be earned every day, by redoubled vigilance in our laboratories, plant and packaging departments.

The products we offer you are doubly reliable···because our friends are depending upon us to keep them so.

THE SMITH-DORSEY COMPANY
Lincoln, Nebraska
BRANCHES AT DALLAS AND LOS ANGELES

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

MANUFACTURERS OF
PURIFIED SOLUTION OF LIVER · DORSEY
SOLUTION OF ESTROGENIC SUBSTANCES · DORSEY

What's Going On In Indiana by the Executive Secretary

Longer State Meeting. The 1947 state meeting will last three days instead of the customary two. The council decided on the extra day to avoid crowding the activities, and to provide an additional full day of scientific program. On Tuesday, October 27, the instructional courses will be given for the first time at French Lick. That evening there will be entertainment for men and women instead of a "men only" party. Wednesday morning, October 29, there will be a general scientific meeting, with the section meetings in the afternoon. The evening will be open for fraternity and class dinners, servicemen's get-together, special committee meetings, et cetera. Thursday morning and afternoon, October 30, will be devoted to general meetings, with a dinner that night closing the 1947 annual session. Special emphasis is being placed on scientific exhibits this year, while the entire mezzanine floor has been set aside for technical exhibits. All indications are that this will be a banner state meeting, with good educational features and plenty of opportunity, too, for fun and relaxation.

——ISMA——

Wanted by the F. B. I. An F. B. I. agent visited the headquarters office the other day to ask that we warn physicians about a fugitive named Hobart Martin Prosser, alias Harry Moore. Prosser's specialty is to gain the confidence of a physician and then inveigle him into purchasing some Canadian stocks which have come into his possession. After closing the deal Prosser manages, through devious schemes, to regain possession of the stock and then disappears. He is sixty-one years of age; has a small brown mole on back of left hand and an irregular scar on upper lip. Prosser has undergone an operation for cancer of the anus and has to carry a pouch on his side for elimination purposes. Mr. J. Edgar Hoover, director of the Federal Bureau of Investigation, will be very pleased if someone can inform him of Prosser's whereabouts.

——ISMA——

Extra Train to Atlantic City. The Pennsylvania Railroad has announced that it will run a special train from St. Louis to Atlantic City for the centennial meeting of the American Medical Association, June 9 to 13, inclusive. The schedules for Indiana follows:

Going, Sunday, June 8, leaves

Terre Haute	12:58 p.m.
Indianapolis	2.30 p.m.
Richmond	3:40 p.m.

The train will leave Atlantic City at 4:35 p.m., Friday, June 13. Arrives Saturday, June 14, at

Richmond	9:53 a.m.
Indianapolis	11:05 a.m.
Terre Haute	12:37 p.m.

The round-trip fare from Indianapolis, lower berth, is $69.70, including tax. Compartments and drawing rooms are available also. If the special train's schedule is not convenient, space is available on regular Pennsylvania trains. Any physician interested in train accommodations to Atlantic City should contact R. M. Harvey, division passenger agent, Pennsylvania Railroad, 211 Guaranty Building, Indianapolis. The Indiana State Medical Association is not sponsoring the train.

——ISMA——

State of Indiana Needs Doctors. The shortage of doctors is still plaguing the State of Indiana. Responsible for the medical care of 19,642 persons (as of February 1, 1947) in its twenty penal and benevolent institutions, the state could use fifteen to twenty more doctors. Most badly needed are psychiatrists. While the salary for physicians has risen to a top of $375 a month, it doesn't attract many men. With most of the positions go nice living quarters and an automobile. Legislation passed by the 1947 General Assembly makes possible payment up to $10,000 a year for medical superintendents. New legislation, too, places supervision of benevolent institutions and all state psychiatric services under the Council on Mental Health, three of the five members of which are physicians. Dr. Norman M. Beatty, of Indianapolis, chairman of the council, would be glad to hear from any doctor interested in working for the state.

——ISMA——

New Veterans Fee Schedule. The Veterans Administration is asking the thirty-eight state medical associations with which it has contracts for "home care" of veterans of World War II to accept a new fee schedule. The move, says the V. A., is to adjust fees so they are in line with those now being charged privately-treated patients in the various states. If acceptable to the state associations, there will be only one fee schedule instead of thirty-eight different ones. A comparison of the new schedule with the Indiana schedule now in effect reveals that, by and large, Indiana physicians will receive more for their services under the new plan. There are, of course, some cuts here and there, but they are minor for the most part. The council has instructed the Veterans Committee to submit the new schedule to all county societies for their approval or disapproval.

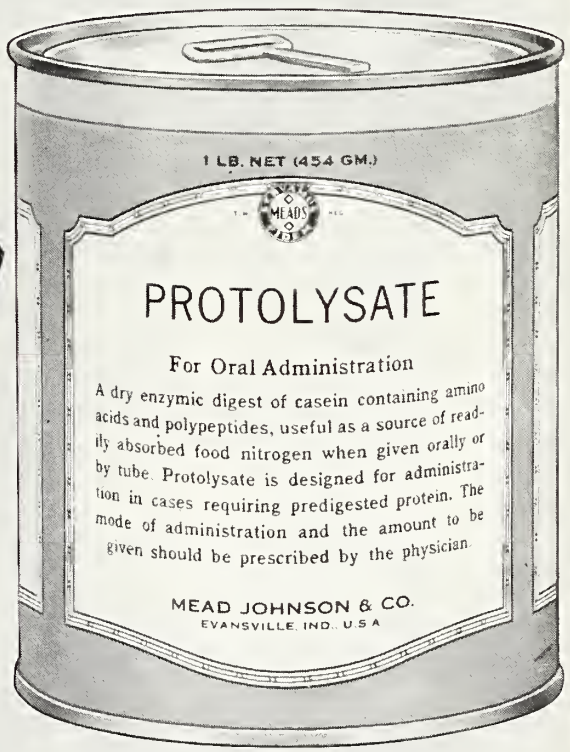
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PROTOLYSATE
for oral and tube feeding of amino acids



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There is no shortage now of AMIGEN for parenteral use. There is no shortage now of PROTOLYSATE for oral use.

News Notes

Announcement has been made of the marriage of Dr. Raymond Merchant and Miss Shirley Irene Hambidge, of Lafayette, on February first. They are residing at 269 South Maxwell Street, in Crown Point.

Dr. Joseph R. Caton has opened an office in the J. M. S. Building in South Bend. Doctor Caton returned to South Bend several months ago after spending forty-four months in the Army Medical Corps. He will limit his practice to the treatment of rheumatic diseases and internal medicine.

Dr. J. H. Rickman, formerly of New Albany, has recently become associated with Dr. J. W. Strange, of Loogootee, in the practice of medicine and surgery.

Dr. C. L. Harless, formerly of Gary, has opened an office in the Johnson Building, in Chesterton, for the practice of medicine and surgery.

Dr. O. T. Kidder, of Fort Wayne, has been appointed medical director of the Irene Byron Sanatorium. Doctor Kidder succeeds Dr. M. H. Draper, who had served as medical director since 1931, and who resigned to become medical director and superintendent of the Drew Field Sanatorium in Tampa, Florida.

Dr. Clifford L. Williams recently resigned as director of the Indiana Council for Mental Health to become the chief of reception services at the Veterans Administration Hospital, in Marion.

Dr. A. A. Sullenger, of Marion, formerly of Indianapolis, and Miss Cuma Cottingham, of Indianapolis, were united in marriage on March eighth. They will reside in Marion.

A marker is being erected by the Huntington County Medical Society, at the site of a log cabin where former Governor Chase S. Osborn, of Michigan, was born more than eighty-seven years ago. The parents of Governor Osborn were pioneer physicians in Huntington County during the days of the Civil War.

Dr. Robert L. Salb, formerly of Jasper, has become associated with Dr. John A. Eisterhold, at 220 South Riverside Drive, in Evansville. His practice will be limited to gynecology and obstetrics.

Dr. Arthur T. Kemper, of Muncie, celebrated fifty years of medical practice in Muncie, on March thirtieth.

Dr. J. B. Cushman has left Gary to accept a position as chief anesthetist in the Morgan Heights Tuberculosis Sanitarium in Marquette, Michigan.

Following the death of Dr. King L. Hull, of Bloomfield, Dr. Jerome A. Graf, also of Bloomfield, has been appointed as coroner of Greene County until a successor has been elected and qualified.

Dr. D. L. Lutes, formerly of Straughn, has opened an office in Edinburg for the practice of medicine.

Dr. Clement Lowell Poston has announced the opening of an office in the First National Bank Building, in Richmond, for the practice of radiology.

Dr. Amos Reusser, of Berne, celebrated the completion of a half century of medical practice on March twenty-third. He has been located in Berne all this time.

After being separated from service in February, Dr. Thomas G. Sheller has opened an office in Argos for the practice of medicine.

Dr. Robert P. Jay has opened an office for the practice of obstetrics at 915 Hume Mansur Building, Indianapolis. Doctor Jay is a Navy veteran, having spent his tour of duty in Oakland, California, and Pearl Harbor, as obstetrician for Navy dependents. Upon being discharged he returned to Honolulu and took advanced training at the Kapiolani Maternity and Gynecological Hospital.

After thirty-four months service in the Army, Dr. Everett L. Kalb has announced the opening of an office for the practice of medicine at 658 Fairfield Avenue, Indianapolis. Doctor Kalb spent twenty months overseas as a combat battalion surgeon with the 95th and 29th Divisions in the European Theater.



Uniformly Good Results

The weight curves represented above are to be found in actual hospital (name on request) records of 75 *consecutive* infants fed on Similac for six months or longer. Not once in this entire series of 75 cases was it necessary to change an infant's feeding because of gastro-intestinal upset.

Similarly good uniform results are constantly being obtained in the practice of many physicians who prescribe Similac routinely for infants deprived, either wholly or in part, of mother's milk.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D, and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

SIMILAC *Similar to breast milk*

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Following forty-four months in the Medical Corps of the Army Air Forces, Dr. O. L. Meyer, formerly of Portland, is now associated with Dr. B. A. Speheger and Dr. E. G. Bridwell, at Bedford. For a year prior to his separation Doctor Meyer served as base surgeon at Wright Field, with the rank of major.

Dr. Earl W. Mericle, of Indianapolis, has recently been awarded the Croix de Guerre for services while on duty with the 4th Armored Division. The citation accompanying the award stated that it was "For exceptional service of war rendered during the operation of the liberation of France. This citation includes the conferring of the Croix de Guerre with the silver star."

Dr. Daniel C. Barrett has been appointed Director of the Division of Local Health Administration of the Indiana State Board of Health. The five branch offices which have recently been established by the State Board of Health at Columbus, Valparaiso, Washington, Terre Haute, and Fort Wayne, will be under the supervision of Doctor Barrett. He will also continue as Director of the Southeastern Branch Office at Columbus, a position he has held since leaving the United States Public Health Service more than a year ago.

Veterans Administration Prescriptions

The Veterans Administration Regional Office, Indianapolis, Indiana, is presenting the following VA-Indiana State Pharmaceutical Association plan.

If you as a participating physician are authorized by the Veterans Administration, in writing, to treat a veteran for his service connected disability, you may prescribe medications for treatment of that disability, and furnish the veteran with a prescription to be filled by the local participating pharmacy. The prescription *must* show the following:

The name and address of the veteran.

The date the prescription is written.

The "C" number, if shown on the VA authority.

The prescription should be written on the physician's regular prescription blank, and must be signed by the physician.

The following legend *must* appear on the back of each prescription, and may be printed, rubber stamped, or written. This statement must also be signed by the physician.

"I am authorized to treat and prescribe for the above-named Veterans Administration patient for ——————."

The service connected disability for which you are authorized to treat the veteran must be shown. Prescriptions must be filled within ten days of the date written if the participating pharmacist is to receive reimbursement. Prescriptions must *not* be written unless you have a current prior authority to treat the veteran, for a service connected disability, issued by the Veterans Administration.

Dr. E. Rogers Smith, of Indianapolis, who is a member of the Advisory Committee, Neuropsychiatry Division, of the Veterans Administration, attended a meeting of that committee in Washington on April 24 and 25.

AMERICAN PSYCHIATRIC ASSOCIATION'S ANNUAL MEETING MAY 19-23

The 103rd annual meeting of the American Psychiatric Association will be held May 19-23 at the Pennsylvania Hotel in New York City. Among the 120 papers to be presented are reports on advances in such diverse fields as child psychiatry, brain surgery, convulsive disorders, shock therapy, alcoholism, and forensic psychiatry. For further information contact the American Psychiatric Association, 200 Retreat Avenue, Hartford, Connecticut.

INDIANA UNIVERSITY NEWS NOTES

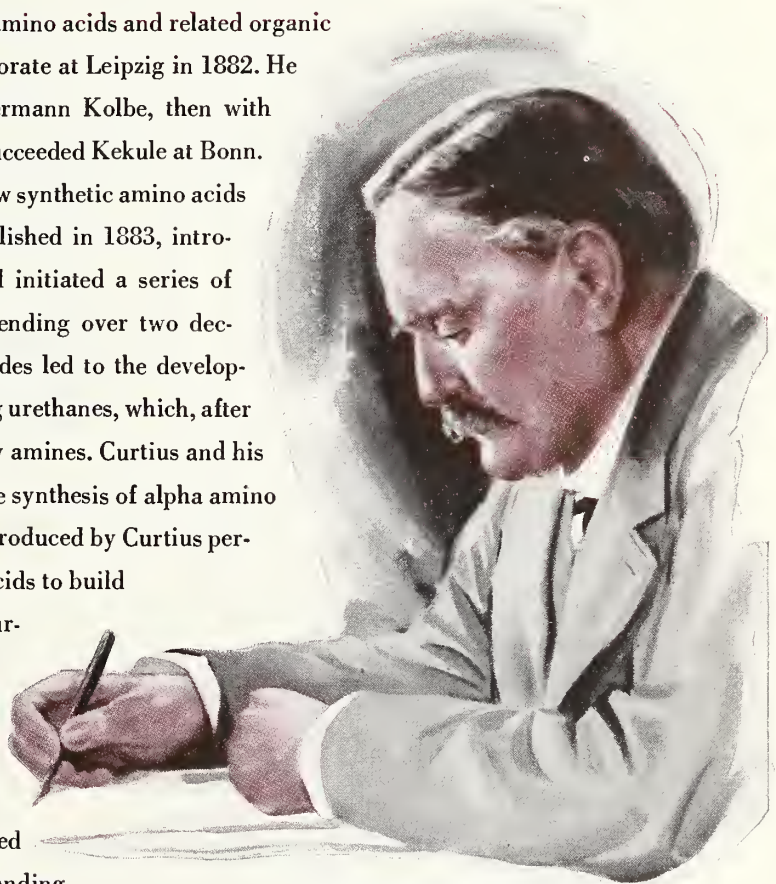
Specialists in the diseases of the ear, nose, and throat, from twenty-one states and the District of Columbia attended the two-weeks postgraduate course March 31-April 11 in their fields at the Indiana University Medical Center. The course, popularly known as the Barnhill Course, due to its establishment in 1915 by the late Dr. John F. Barnhill, of Indianapolis, was attended by the capacity number of forty specialists. It was conducted by Drs. C. H. McCaskey and E. N. Kime of the Indiana University School of Medicine. Indianapolis specialists were hosts to the visiting physicians the night preceding the opening of the course at a dinner at the Indianapolis Athletic Club. Dr. C. Stewart Nash, University of Rochester School of Medicine and Dentistry, spoke on "The Functional Diseases of the Nose."

Dr. Dwain Newton Walcher, instructor in pediatrics at Yale University, 1943-46, has been appointed to the newly created position of assistant professor of pediatrics in the Indiana University School of Medicine. Doctor Walcher has the M.D. degree from the University of Chicago and interned in the Indiana University Medical Center 1940-41, and at the Yale University Medical School (New Haven Hospitals) 1942-43. The following two years he was resident at the New Haven Hospitals.

Dr. Louis W. Spolyar has been named to the newly created position of assistant professor of public health (part-time) in the Indiana University School of Medicine. He has the M.D., cum laude, degree from the Indiana University School of Medicine and has done postgraduate work in industrial medicine at the University of Michigan. Since 1938 Doctor Spolyar has been director of the Division of Industrial Hygiene for the Indiana State Board of Health.

Men and Amino Acids

This eminent investigator of amino acids and related organic compounds obtained his doctorate at Leipzig in 1882. He was associated first with Hermann Kolbe, then with Adolph Baeyer; in 1896 he succeeded Kekule at Bonn. His dissertation on several new synthetic amino acids related to hippuric acid, published in 1883, introduced diazoacetic esters, and initiated a series of systematic investigations extending over two decades. His work with acid azides led to the development of a method of preparing urethanes, which, after acid hydrolysis, yield primary amines. Curtius and his pupils evolved methods for the synthesis of alpha amino acids. Acid azide reactions introduced by Curtius permitted the linkage of amino acids to build polypeptides. As a teacher, Curtius attracted students from many countries. His elucidation of numerous problems associated with the chemistry of amino acids pointed the way to a clearer understanding of proteins and protein derivatives and their role in nutritional science.



THEODOR CURTIUS—1857-1928

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Fifth in a series

Deaths

Joseph J. Gramling, M.D., of Indianapolis, died March eighteenth, at his home, at the age of sixty-eight years. Doctor Gramling graduated from the Indiana University School of Medicine, in Indianapolis, in 1908. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

John F. Habermel, M.D., of New Albany, died on April fourth, at the age of forty-six years. Doctor Habermel was a graduate of the University of Louisville School of Medicine, in 1928, and had specialized in surgery. He was a member of the Floyd County Medical Society, the Indiana State Medical Association, the American College of Surgeons, and was a Fellow of the American Medical Association.

* * *

George W. Wood, M.D., of Indianapolis, died at his home on March sixteenth, following a short illness. He was sixty-seven years of age. Doctor Wood graduated from the Indiana University School of Medicine, in Indianapolis, in 1908. He had served as a surgeon and lieutenant-commander in the Navy during World War I. For the past twenty-five years he has been a surgeon in Indianapolis, specializing in gynecology and cystology. Doctor Wood was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Homer H. Tallman, M.D., of Culver, died on March twenty-ninth, following a short illness. He was seventy-four years of age. Doctor Tallman graduated from the Northwestern University Medical School, in Chicago, in 1900. He had served in the Army Medical Corps during World War I and at the time of his death was a major in the United States Army Medical Reserve. Doctor Tallman was a member of the Marshall County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

King L. Hull, M.D., of Bloomfield, died on March sixteenth, after an illness of several weeks. He was forty-nine years of age. Doctor Hull graduated from the Indiana University School of Medicine, in Indianapolis, in 1929. He was a member of the Greene County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Henry W. Armistead, M.D., of Indianapolis, died March twenty-fifth, after a short illness. He was seventy-nine years of age. Doctor Armistead graduated from the Meharry Medical College, of Nashville, in 1894, and for more than forty years had been a practicing physician in Indianapolis.

* * *

Walter M. McGaughey, M.D., of Greencastle, died March twenty-fourth, at his home, at the age of seventy-six years. Doctor McGaughey graduated from the Medical College of Indiana, in Indianapolis, in 1902. He was a member of the Putnam County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Albert M. MacBeth, M.D., of Fort Wayne, died March tenth, at his home. He was eighty-four years of age. Doctor MacBeth graduated from the University of Buffalo School of Medicine, in 1892, and was a practicing surgeon for over forty years. He was an Honorary member of the Fort Wayne (Allen County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

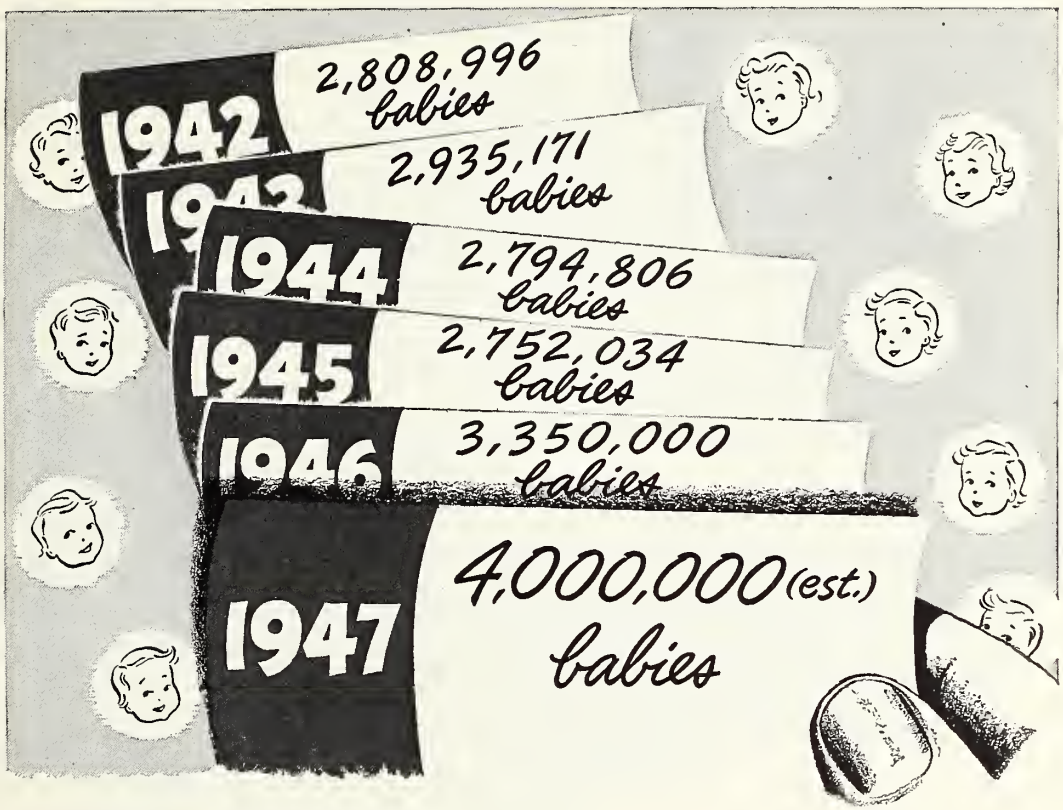
Junius L. Lambert, M.D., of Brazil, died January second, at the age of eighty-six years. Doctor Lambert graduated from the Central College of Physicians and Surgeons, in Indianapolis, in 1902. He was an Honorary member of the Clay County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

W. E. Ticen, M.D., of Shirley, died on January fourth, at the age of seventy-two years. Doctor Ticen graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906.

* * *

Delbert O. Kearby, M.D., of Indianapolis, died on April tenth, at the age of sixty-nine years. Doctor Kearby graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906. He had practiced in Indianapolis for approximately twenty-five years, specializing in bronchoscopy and esophagoscopy, before his retirement in 1937. He was a member of the American Academy of Ophthalmology and Otolaryngology.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

March 10, 1947.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

Copy was approved for the following "Hints on Health" columns:

Week of March 24, 1947—"Acute Pleurisy."

Week of March 31, 1947—"Promiscuous Spitting."

A Public Relations Bulletin issued by the Michigan State Medical Society was read.

Report of a conference of executive secretaries and others to discuss public relations, held at Chicago February 8, 1947, was noted.

The bureau decided to ask the Bureau of Health Education, American Medical Association, for radio transcription series entitled, "More Life for You," for use over WFBM, Indianapolis, beginning April 14, 1947.

BUREAU OF PUBLICITY

March 24, 1947.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

A news release to be mailed March 29, 1947, to all dailies and weeklies in Indiana, entitled, "Measles Should Be Regarded as Serious Disease," was approved.

Copy was approved for the following "Hints on Health" columns:

Week of April 7, 1947—"Muscular Rheumatism."

Week of April 14, 1947—"Psoriasis."

Week of April 21, 1947—"Don't Neglect Hernia."

Purchase of 3,500 copies of a pamphlet reviewing the Kaadt Diabetic Institute, issued by the Indianapolis Better Business Bureau, for distribution by the Council on Medical Service of the American Medical Association, was approved. An additional hundred copies was ordered by the bureau for the headquarters office of the association.

Letter from Connecticut State Medical Society stating that it is beginning a health column for weekly newspapers similar to "Hints on Health" was read.

LOCAL SOCIETY REPORTS

Adams County Medical Society members held a meeting at the Adams County Memorial Hospital on March eleventh, at which the guest speaker was Dr. H. E. Dester, who spoke on "The Practice of Medicine in India." Doctor Dester also showed pictures taken in India.

Boone County Medical Society members held a dinner meeting on March fourth in the Witham Memorial Hospital, in Lebanon. In addition to the regular business meeting, plans were discussed for the immunization of grade school pupils in Boone County.

Elkhart County Medical Society members held a dinner meeting on March sixth in the Hotel Elkhart. Guest speaker for this meeting was Dr. Samuel W. Banks, Northwestern University, who presented an illustrated talk on fractures and bone defects. Sixty doctors were present.

The members held a dinner meeting at the Hotel Elkhart, in Elkhart, on April third. The guest speaker was Dr. George J. Garceau, of Indianapolis, who discussed "Indications for Physical Therapy." A movie, sponsored by the Society for Crippled Children, demonstrating physical therapy in poliomyelitis, was also shown. Fifty members attended the meeting.

Fayette-Franklin County Medical Society members met on March eleventh in the McFarlan Hotel, in Connersville. The guest speaker was Dr. W. C. Vance, of Richmond, who discussed "Erythroblastosis Fetalis." Fifteen members were present.

The members met on April eighth, at the McFarlan Hotel, in Connersville. Dr. Charles F. Thompson, of Indianapolis, spoke on "Common Diseases and Injuries of the Shoulder Joint." Seventeen members were in attendance.

Floyd County Medical Society members met at New Albany on March fourteenth. The eighteen members present discussed the immunization program.



Demerol hydrochloride ranks between morphine and codeine in analgesic power. Furthermore, it possesses marked spasmolytic and mild sedative action. It causes less nausea and vomiting and less urinary retention than morphine, and no constipation. The danger of respiratory depression is also greatly reduced with Demerol hydrochloride. Warning: May be habit forming. Ampuls of 2 cc. (100 mg.) and tablets of 50 mg. Narcotic blank required.

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Greene County Medical Society members held a meeting at the Freeman Greene County Hospital, in Linton, on March thirteenth. Dr. Harry G. Rotman, of Jasonville, discussed "Headaches." Ten members attended the meeting.

Hamilton County Medical Society members met at Westfield on February twelfth. The speaker was Dr. Harvey W. Sigmond, of Indianapolis. Twelve members were present at this meeting.

At another meeting on March eleventh, at Noblesville, Dr. Wemple Dodds, of Crawfordsville, was the speaker. Eleven members attended the meeting.

Lawrence County Medical Society members held their regular dinner meeting on February fifth at the Dunn Memorial Hospital. Dr. George Bowman, of Indianapolis, outlined the work that is being done by the Indiana State Board of Health in combatting venereal disease in Indiana.

Madison County Medical Society members met at the Anderson Country Club, on February twenty-first, to hear Dr. John R. Brayton, of Indianapolis, speak on skin diseases. Mr. Guy W. Spring, executive director of Blue Cross, also addressed the group.

Marshall County Medical Society members met at Coral Gables, at Plymouth, on March twelfth. The speaker at this meeting was Dr. Ernest L. Dietl, of South Bend, whose subject was "Etiology and Control of Nasal Hemorrhage."

Montgomery County Medical Society members held a meeting at the Culver Hospital, in Crawfordsville, on March twentieth. Dr. C. J. Clark, of Indianapolis, spoke to the twenty-one members present on "Thiouracil in the Treatment of Hyperthyroidism."

Morgan County Medical Society members met on March nineteenth at the Morgan County Memorial Hospital, in Martinsville. "The Rh Factor" was the subject chosen by Leon Gray, M.D., of Martinsville, who was the speaker of the evening.

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, in Clinton, on March nineteenth. The eleven members in attendance heard Dr. James S. Browning, of Indianapolis, speak on "Diseases of the Joints."

Porter County Medical Society members met at the Porter Memorial Hospital, in Valparaiso, on March twenty-fifth. Dr. B. D. Braun, of East Chicago, spoke on "The Use of X-rays and Radium in Therapeutics." A Blue Cross representative also addressed the eighteen members present.

Pulaski County Medical Society members met at Chapman's Cafe, in Winamac, on March sixth for the election of officers.

Putnam County Medical Society members held a dinner meeting on March thirteenth, in Greencastle. The ten members present heard Dr. Carl P. Huber, of Indianapolis, discuss "Management of Cervical Lesions."

Tippecanoe County Medical Society members met at the Lincoln Lodge, in Lafayette, on March eleventh. The speaker for the evening was Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association. Forty-five members attended the meeting.

The members held a dinner meeting at the Lincoln Lodge, in Lafayette, on April eighth. The guest speaker was Dr. John L. Richert, of Chicago, whose subject was "Modern Trends in Immunization." The meeting was attended by sixty-five members.

Vanderburgh County Medical Society members held a meeting at the McCurdy Hotel, in Evansville, on March eleventh. The guest speaker was Dr. Lyman T. Meiks, of Indianapolis, who discussed diagnosis of respiratory obstructions.

Wabash County Medical Society members met in the Wabash Country Club on March fifth for a discussion of current business. Twelve members were present.

TENTH COUNCILOR DISTRICT

Dr. Floyd T. Romberger, Sr., of Lafayette, president of the Indiana State Medical Association, and Ray E. Smith, of Indianapolis, executive secretary, were principal speakers at the Tenth Councilor District Meeting held at Teibel's Restaurant, Schererville, the night of April 10.

Dr. David R. Johns, of East Chicago, president of the Lake County Medical Society, and chairman of the Indiana State Board of Health, explained some of the bills sponsored by the board in the recent state legislature.

Dr. George M. Cook, of Hammond, president of the district society, presided. The next district meeting will be held in October.



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WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Recording Secretary—Mrs. J. L. Allen, Greenfield.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. O. H. Bakemeier, Indianapolis.

NOTICE

Last call for reservations for the twenty-fourth annual convention of the Woman's Auxiliary to the American Medical Association, which will be held at Haddon Hall Hotel, Atlantic City, New Jersey, June 9 to 13.

Atlantic City extends a hearty welcome to you.

* * *

Three resolutions were adopted at the 1946 Convention of the Woman's Auxiliary to the American Medical Association which are of interest to the Indiana Auxiliaries. They are as follows:

I. Resolution Recommending Conferences of State Auxiliaries.

WHEREAS, The conference of presidents, presidents-elect, and chairmen of standing committees of the Woman's Auxiliary to the American Medical Association has proved to be profitable to its members; and

WHEREAS, The Woman's Auxiliary to the Ohio State Medical Society has instituted a similar conference at its mid-year board meeting, which was very successful; therefore be it

Resolved, That the Woman's Auxiliary to the American Medical Association recommends that all state auxiliaries institute a conference of county presidents, presidents-elect, and chairmen of standing committees.

II. Resolution Recommending the Organization of Study Groups

Resolved, That the Woman's Auxiliary to the American Medical Association, in convention assembled July, 1946, reaffirms the principles set forth in the resolution pertaining to study groups for state and county auxiliaries adopted at its sixteenth annual meeting held in San Francisco, June, 1938. The resolution is as follows:

WHEREAS, There is much propaganda in the daily press and in lay periodicals and magazines concerning the socialization of medicine; and

WHEREAS, It is one of the duties of the members of the Auxiliary to bring to the lay public the answer of the medical profession to the misleading statements which such propaganda contains; and

WHEREAS, In order to perform this duty intelligently, the members of the Auxiliary must themselves be informed of the point of view of the medical profession; and

WHEREAS, Such information can best be given to the members of the Auxiliary by their medical advisors and by reading the organization section of the Journal of the A.M.A. and also the sections devoted to medical economics in the journals of the state medical societies; therefore be it

Resolved, In accordance with the repeated suggestion of Dr. Irvin Abell, president of the American Medical Association, recommends to, and urges on, the presidents of auxiliaries to state medical societies the organization in all county auxiliaries of study groups, dealing with the dissemination of accurate knowledge concerning the harmful effects of present social and economic movements on the practice of medicine.

III. Resolution Requesting an Annual School of Instruction.

WHEREAS, The Woman's Auxiliary to the American Medical Association can attain the objects stated in its constitution only through the efforts of well informed members and officers and committee chairmen who clearly understand their duties and responsibilities; and

WHEREAS, In 1944 one of the constituent auxiliaries adopted a school of instruction program, in which the objects of the Auxiliary and the duties and responsibilities of officers and chairmen have been studied with much profit to its members; therefore be it

Resolved, That the constituent state Auxiliaries be requested by the House of Delegates of the Woman's Auxiliary to the American Medical Association to adopt and put into effect an annual School of Instruction Program.

* * *

Read your June issue of THE JOURNAL and find out what interesting reports were read at the third annual meeting of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association, held in Indianapolis, April 22 and 23.

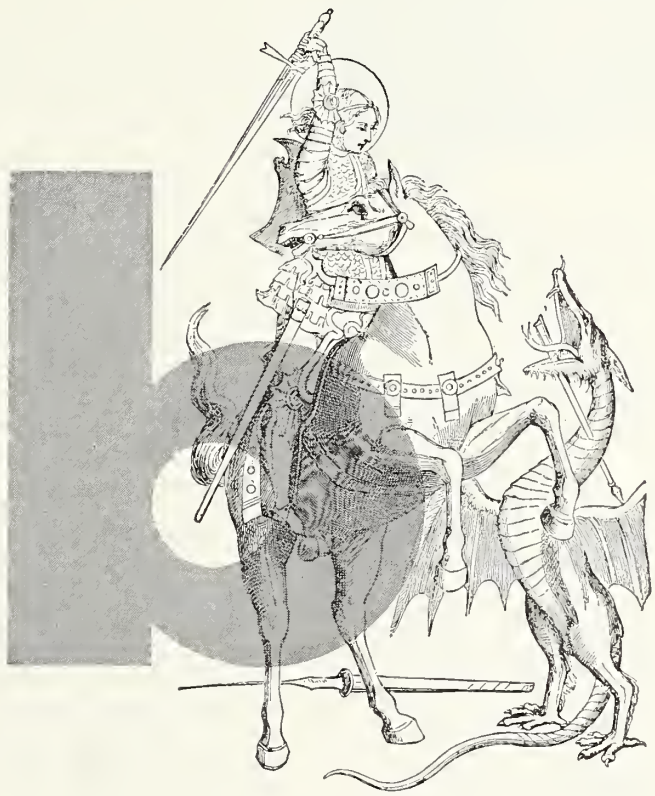
Allen County

This is the first publicity for the Allen County Auxiliary this year, and it has accomplished much. There are eight yearly meetings—four business and four social. In September the annual tea was given. In December a Christmas Party was held with the County Medical Society. In February there was a Valentine Dessert-bridge Party, and in April a joint Dinner Party with the Medical Society.

Their projects are:

I. Collection of instruments and drugs for foreign countries.

II. A course in "Grooming for Glamour" is planned for each recreation center in the city of Fort Wayne, and auxiliary members will conduct the classes. Instruction includes the care of hair, teeth, nails, diet, and costuming. At the end of the six weeks' course a style show is sponsored by the Auxiliary, with cokes and cookies for refreshments. Auxiliary members' daughters assist as models.



to combat

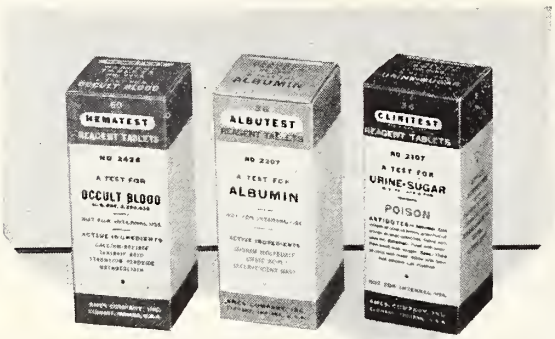
the depression of

chronic organic disease Many patients with chronic organic disease—arthritis or asthma, for example—sink into a persistent depression characterized by discouragement, or even despair. Unless effectively combated, this depression may handicap management of the basic disorder and intensify its symptoms.

By restoring optimism and interest in useful living, Benzedrine Sulfate frequently helps to overcome prolonged depression accompanying chronic illness. Obviously, in such cases, careful observation of the patient is desirable; and the physician will distinguish between the casual case of low spirits and a true mental depression.

benzedrine sulfate (*racemic amphetamine sulfate, S.K.F.*) Tablets and Elixir

Smith, Kline & French Laboratories, *Philadelphia, Pa.*



The Diagnostic Family is Growing

A new member has been added to the ever-growing Ames Diagnostic Family. The name of the latest arrival is—Hematest.

Here are the 3 members of the group to date:

1. *Hematest*

Tablet method for rapid detection of occult blood in feces, urine and other body fluids. Bottles of 60 tablets supplied with filter paper.

2. *Albutest*

(*Formerly Albumintest*)

Tablet, *no heating* method for quick qualitative detection of albumin. Bottles of 36 and 100.

3. *Clinitest*

Tablet, *no heating* method of detection of urine-sugar.

Laboratory Outfit (No. 2108).

Plastic Pocket-size Set (No. 2106).

Clinitest Reagent Tablets (No. 2101) 12x 100's for laboratory and hospital use.

All products are ideally adapted to use by physicians, public health workers and in large laboratory operations.

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Lake County

Mrs. Russell Palmer, of Gary, was hostess to the Gary-South Branch of the Lake County Auxiliary, in March. A short business meeting was conducted by Mrs. Harry R. Stimson. Mrs. Carl O. Almquist was appointed delegate to the meeting of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association, which convenes the last Tuesday and Wednesday of April of each year. Mrs. Carl H. Bendler was hostess in April.

Porter County

On March twenty-fifth the Auxiliary met at the home of Mrs. Arthur J. VanWinkle, for a dinner in honor of Mrs. S. J. Petronella, the State President. Following the dinner, Mrs. Petronella gave a most interesting and instructive talk on organization problems. An informal discussion followed. During the business session the new officers were elected.

Sullivan County

The Woman's Auxiliary to the Sullivan County Medical Society met on Friday, April 11, for a luncheon at the Hotel Sullivan. During the luncheon Mrs. Rudolph Wernz entertained with piano selections. Mrs. H. C. O'Dell, the auxiliary president, presided and introduced Miss Cook, superintendent of the Mary Sherman Hospital, who explained hospital insurance. Mrs. I. H. Scott presented Dr. J. B. Maple, who gave a talk on the recent advances in medicine. Mrs. S. J. Petronella, the state president, was the honor guest. She was introduced by the county president and gave a talk on state medicine and the work of various auxiliaries in the state.

Vanderburgh County

The Woman's Auxiliary held a dinner meeting and election of officers at the McCurdy Hotel in March. A film was shown of the activities at the crippled children's summer camp at Camp Optimist.

Books

REVIEWED

THE CARE OF THE AGED (GERIATRICS). Fifth edition. By Malford W. Thewlis, M.D., 500 pages with 44 illustrations. Fabrikoid. Price $8.00. The C. V. Mosby Company, St. Louis, 1946.

Most doctors treat old people, and here is an engrossing manual on that subject. So many doctors are of the age group between fifty and eighty that it is of intense personal interest to know more about yourself as you advance in years. One chapter on geriatric nursing is a much needed lecture in most hospitals. The discussion on surgery, the choice of anesthesia, the pre- and postoperative care contains the very best advice concerning these bad risks. Not the least valuable is the voluminous bibliography for further pursuit of the subject.

Charles N. Combs.

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Division of Communicable Disease Control

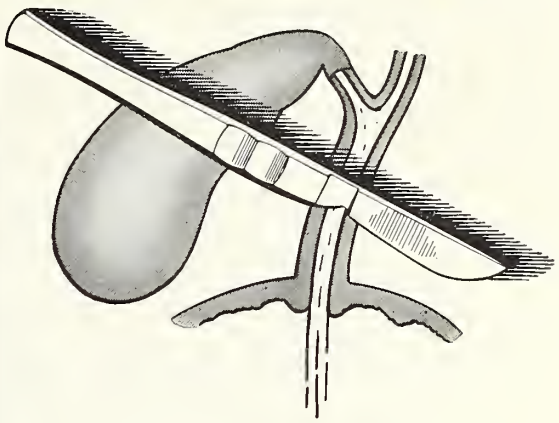
MONTHLY REPORT—JANUARY—1947

Diseases 1947	Jan. 1947	Dec. 1946	Nov. 1946	Jan. 1946	Jan. 1945
Tuberculosis, Pulmonary	227	113	256	...	...
Tuberculosis, Other Forms	21	2	2	...	...
Chickenpox	575	455	423	297	563
Measles	81	36	44	212	27
Scarlet Fever	479	281	280	302	521
Smallpox	8	5	...	2	6
Malaria	8*	14	13	19*	1* 2-
Typhoid Fever	7	4	6	1	4
Impetigo	12	10	22	11	2
Whooping Cough	132	94	109	83	54
Diphtheria	58	58	46	62	24
Brucellosis	25	10	27	1	11
Influenza	69	19	23	405	28
Pneumonia	91	33	31	36	13
Conjunctivitis	1	3	3	1	...
Mumps	117	33	43	49	220
Trichinosis	2	.	...	1	...
Poliomyelitis	13	12	65	2	3
Tuber. Meningitis	1	...	...	...	...
Cerebro-Spinal Meningitis	7	6	4	12	19
Meningococci-Meningitis	5	6	2	...	...
Meningitis-Influenza	4	2	...	...	...
Meningitis-Diptheric	1	...	...	...	...
Pneumococci-Meningitis	1	1	1	...	...
Tularemia	24	41	2	3	6
Meningitis-Strepto.	1	...	...	...	...
Encephalitis-Lethargic	5	2	7	1	1
Septic Sore Throat	25	13	7	13	...
Erysipelas	6	2	3	1	1
Rubella	8	1	2	2	4
Rocky Mt. Spotted Fever	1	...	...	...	...
Jaundice Infectious	6	2	1	1	...

* Malaria Acquired outside of United States
\- Malaria Acquired inside of United States

MONTHLY REPORT — FEBRUARY — 1947

Diseases 1947	Feb. 1947	Jan. 1947	Dec. 1946	Feb. 1946	Feb. 1945
Tuberculosis, Pulmonary	139	227	113	...	...
Tuberculosis, Other Forms	3	21	2	...	...
Chickenpox	498	575	455	273	480
Measles	162	81	36	1150	49
Scarlet Fever	473	479	281	449	717
Smallpox	1	8	5	2	6
Malaria—Outside U.S.	7	8	14	10	...
Typhoid Fever	9	7	4	4	2
Brucellosis	8	25	10	3	6
Whooping Cough	181	132	94	80	73
Diphtheria	50	58	58	71	33
Influenza	162	69	19	200	39
Pneumonia	37	91	33	35	13
Mumps	139	117	33	90	278
Trichinosis	1	2	...	...	...
Poliomyelitis	2	13	12	1	1
Meningococcic-Meningitis	3	5	6	...	...
Cerebro-Spinal Meningitis	3	7	6	14	12
Meningitis—Influenzal	3	4	2	...	...
Encephalitis—Infectious	6	5	2	2	...
Impetigo	5	12	10	8	2
Tularemia	5	24	41	5	2
Septic Sore Throat	24	25	13	10	4
Erysipelas	4	6	2	2	10
Dysentery	1	...	...	...	1
Tinea Capitus	59	...	...	...	...
Food Poisoning	1	...	...	4	...
Salmonellosis	1	...	...	...	...
Epilepsy	4	...	...	...	...



Surgical Principle Accomplished Medically

Drainage in the presence of infection or congestion is a sound surgical principle.

In chronic inflammatory conditions of the bile passages without stones, drainage is accomplished by increasing the production and flow of free-flowing, low viscosity bile, employing Decholin for its hydrocholeretic action.

Decholin (dehydrocholic acid) stimulates the production of thin bile by the liver cells, with a resultant cleansing action on the entire biliary tract.

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Decholin is supplied in boxes of 25, 100, 500 and 1000 3¾ gr. tablets.

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FURACIN—A new chemotherapeutic compound for treatment of wounds and surface infections.

ANTI RH SERUM—A diagnostic agent for the rapid and accurate determination of RH factor in human blood by the microscopic slide agglutination method.

BLOOD GROUPING SERA—(Powdered) Anti A Anti B

Literature available on request.

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"Salinidol"
(Doak)
Indicated in Treatment of
RINGWORM INFECTION OF THE SCALP
*"Salinidol"
(Salicylanilid and Carbowax)
Salicylanilid 5% — Carbowax 95%
Formula: U.S.P.H. Service, Washington, D.C.

"Salinidol" is greaseless, stainless, and odorless. Easily removed from the scalp with water.
Ringworm of the Scalp in this epidemic is mostly due to *Microsporon Audouini*. Occasionally the infection is due to *Miscrosp. Lanosum*.

SUGGESTION FOR TREATMENT:
1. The hair in each case must be clipped close to scalp and kept short by clipping every ten days.
2. The child may have its hair washed at home before going to school or as often as necessary.
3. "SALINIDOL" should be rubbed thoroughly into the scalp daily and treatment continued for about 60 days or longer.

Obtainable in 4 oz., 1 lb. and 5-lb. jars or on prescription.

Sample on Request

* "Ringworm of the Scalp," J.A.M.A., September 14, 1946.

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45 years under the same management

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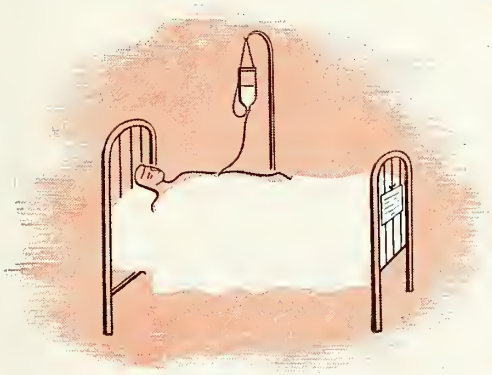
PREOPERATIVE

PREPARATION

"... the protein deficient individual is a poor operative risk."
Lund and Levenson: J.A.M.A. 128:95, 1945

"When time is available to improve protein nutrition before surgery and when this time is used efficiently for this purpose, the reduction in postoperative shock and other complications is impressive."

Editorial: Surg., Gynec. & Obst. 83:259, 1946



POSTOPERATIVE

REPARATION

"... the patient maintained in positive nitrogen balance recovers from major surgery more rapidly than does the patient who is not in nitrogen equilibrium."

Koop: Geriatrics 1:269, 1946

Parenamine
Parenteral Amino Acids
FOR PROTEIN DEFICIENCY

Preparative: To improve and protect the nutritional status of the severely malnourished or critically ill patient . . . as fortification against the shock of major surgery.

Reparative: To provide, in ample quantity, the amino acids essential to tissue repair . . . to hasten healing and shorten convalescence.

Parenamine is a 15 per cent sterile solution of all the amino acids known to be essential for humans . . . derived by acid hydrolysis from casein and fortified with *dl*-tryptophane.

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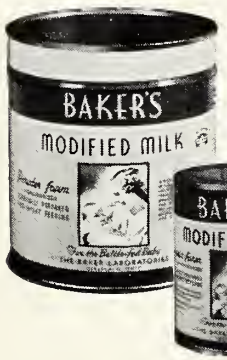


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meets all requirements for Bottle-fed Infants

When you prescribe Baker's Modified Milk you can be sure that in most cases no change in the formula will be necessary. Baker's is well supplied with the nutritive elements for normal growth and is fortified with seven dietary essentials, including liberal protein content (60% more than human milk). As the baby grows older, quantity of feeding is increased.



POWDER

Start with either and change from one to the other, to suit individual requirements. Powder form is especially convenient when traveling.

LIQUID

Doctors, hospital nurses and mothers are delighted by the continuous effectiveness of Baker's Modified Milk either complemental to or entirely in place of mothers milk, starting at birth and continuing through the bottle-feeding period. When you prescribe Baker's, you reduce the possibility of error—only one simple operation is required: dilute with water, previously boiled.

Baker's Modified Milk is a completely prepared infant food that closely conforms to human milk in nutritional results.

. . . is well tolerated by both premature and full-term infants . . .

. . . may be used either complemental to or entirely in place of human milk . . .

. . . may be prescribed at any period—at birth or when mother's milk fails . . .

. . . is helpful in correcting regurgitation, constipation, loose or too-frequent stools . . .

Just leave instructions at the hospital. The obstetrical supervisor will be glad to put your next bottle-fed infant on Baker's Modified Milk.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per quart.

Complete information and samples gladly sent to physicans on request.

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Secretary, Eugene F. Boggs, M.D., Indianapolis.

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For Two Years (terms expire Dec. 31, 1948): H. G. Hamer, M.D., Indianapolis, and A. S. Giordano, M.D., South Bend. Alternates: Karl R. Ruddell, M.D., Indianapolis, and N. K. Forster, M.D., Hammond.

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2	James H. Crowder, Sullivan	Acting
3	A. P. Hauss, New Albany	Dec. 31, 1949
4	Charles F. Overpeck, Greensburg	Dec. 31, 1947
5	A. M. Mitchell, Terre Haute	Dec. 31, 1948
6	W. U. Kennedy, New Castle	Dec. 31, 1949
7	Cyrus J. Clark, Indianapolis	Dec. 31, 1947
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ATOMIC BOMB SURFACE BURNS

Some Clinical Observations Among Prisoners of War Rescued at Nagasaki, Kyushu*

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WILLIAM A. MEISSNER, M.D.***

AMONG the prisoners of war rescued at Nagasaki were nine Javanese who had received surface burns as a result of the activated atomic bomb over that city August 9, 1945. They came under our observation thirty-five days after the bombing and were treated over a period of two weeks. Their lesions had several points of interest; they were not associated with other trauma or injury, the distribution of them over the body was bizarre, and they had developed and progressed in the manner of ordinary sunburns.

POSE AND WEARING APPAREL

Much of the character and distribution depended upon the position of the body and the wearing apparel at the time of exposure. The meaning of pose in relation to these burns is not difficult when it is remembered that the skin-burning rays caused the injury in the brief moment of the explosion. The rays caught these men in various poses much like the light from a bulb-flash would catch a similar group in photography.

At the critical moment they were working in open areas. Some were carrying boards and scrap, some were pushing carts, and others were empty-handed. It was near the noon hour on a summer day. They were sweaty. They wore as little clothing as possible; six men were shirtless; two had reduced their trousers to shorts; one was capless.

SURFACE ANATOMY AND INCIDENCE OF RAYS

Aside from the pose, the surface anatomy of a given part had much to do with the depth of the burns. A study of the lesions indicated that the body surfaces receiving the rays at right angles were more deeply burned than those receiving them obliquely. For example, a man having stood in such a position as to have received third degree burns on the summits of his shoulders would show second degree burns on the receding slopes of the chest and arms (Plate IX). As a body surface continued to recede from the plane of exposure the burn continued to become milder. The margin of such a burn was the zone that corresponded to the greatest obliquity of the surface to the plane of exposure and to the least effectiveness of the rays (see left forearm, Plate III). This correlation of the surface features of the body with the direction of the rays made the puzzling variation of depths and outlines of many of the burns completely understandable.

THE CHARACTER AND PROGRESS OF THE BURNS

The skin lesions of the nine cases had the appearance of ordinary third and second degree thermal burns without significant ulceration and

* This material, obtained from the rescued men while they were aboard the *USS HAVEN*, was a part of a general report of the ship's activities at Nagasaki. The authors had been assigned the duty of making a report on the burns. By the courtesy of the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., this account of the medical aspects of the burns was released for publication.

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scarring. A number of areas were encrusted with dried serous exudate which could be lifted off in flakes (forearm, Case One). A few blebs were still present. Healing appeared entirely satisfactory. Treatment had been consistent with that ordinarily given for thermal burns. There was no hematological evidence of injury to the blood-forming tissues in these patients. (See Table 1.)

TABLE NO. 1

SUMMARY OF LABORATORY FINDINGS

Case No.	X-Ray of Chest	Urinalysis	Serum Proteins*	Hematocrit*	HGB*	WBC
1	Neg.	Neg.	8.2	36	12.2	
2	Neg.	Neg.	7.9	38	12.8	8,650
3	Neg.	Neg.	8.8	34	11.4	11,400
4	Neg.	Neg.	7.3	45	15.2	5,200
5	Neg.	Neg.	7.4	43	14.2	10,600
6	Neg.	Neg.	8.2	45	15	9,200
7	Neg.	Neg.	6.3	50	16.8	9,050
8	Neg.	Neg.	7.9	36	12.2	6,850
9	Neg.	Neg.	7.4	42	14.5	8,400

* The serum protein, hematocrit and hemoglobin findings were obtained by the copper sulfate specific gravity method.

Protection by Clothing

Each of the nine prisoners wore cotton clothing. The cap, jockey style, was part paper and part cotton fabric. The cotton shirts had collars and full length sleeves. The trousers were full length. The color of the garments was uniform, being a blend of pale green and brown. The shoes were made of cloth and rubber, without laces. They were fastened to the feet with hooks behind the heels. Two or three of the men had managed to obtain leather shoes. None of the men wore socks or underwear.

The parts of the body covered by the clothing were protected except for small flame-shaped zones of second degree burns. Various explanations have been given to account for these burns but the most logical one for our cases is based upon the direct transmission of heat to the skin from the hot fabric.* It is assumed that the clothing, dampened with perspiration, stuck to the skin at these zones and they were burned because the insulating layer of air between the skin and fabric was absent (Plates I, III, and X show some of these burns). Another explanation is based upon the presence of heat-absorbing objects† in the pockets of the garments. The outlines of such burns should correspond to the outlines of the heated objects.

The men who had open shirt collars and bosoms showed V-shaped burns of the neck and chest (Plates I, X). It was easy to spot the man who had worn shorts, for his legs, from the knees down to his shoes, presented burns (Plate I). Those whose shirt sleeves were rolled up received burns on the forearms. The forehead was regularly protected by the visor of the cap. Where there was a hole in the clothing the skin beneath it was burned (note left shoulder, Plate X).

* Suggested by Capt. Shields Warren (MC) USNR, U. S. Naval Technical Mission to Japan.

† Suggested by Col. Stafford L. Warren, Manhattan District.

Protection by Hair

Long, thick hair, such as that of the scalp, gave complete protection to the underlying skin (Plates IV and V). The short, sparse hair of the temple, of a closely cropped mustache, or of the unshaven beard gave little or no protection. When such areas were burned much of the original hair had disappeared (Plate II).

Distribution of the Burns

The distribution was bizarre when first seen but after an analysis of the lesions was made it was found to conform to protected zones and to pose. The protected zones were those areas covered by clothing, long, thick hair, and interposed objects such as an arm thrown against the chest (Plates VI, VII, and VIII illustrate arm shadows). Other protruding parts of the body protected areas in a similar manner (see normal area at the upper part of the neck in the shadow of the chin, Plate VIII; large area on chest and front of neck in the shadow of the head and jaws, Plate IX; elongated area in the shadow of the vertebral border of the left scapula and the slightly wider zone behind the left lumbar muscle group, Plate V; and the area on the left cheek in the shadow of the nose, Plate XI). When there were burns on the back there were none on the chest. There were streak-burns along the fingers that recalled the shine from polished rods. (Plates I and III.)

Margins of the Burns

Narrow margins were generally produced by the edges of clothing and interposed objects but those bordering the streak-burns of the fingers have another explanation. Here, and in other similar anatomic situations, only a few of the rays struck the skin at effective angles because the contour of the finger was such as to bend the surface sharply from the plane of exposure. More gradually curved surfaces, on the other hand, presented burns with broader margins. The width of these margins varied inversely with angle of curvature. (Compare the broad margin on the left forearm with the margin of the streak-burn of the fingers in Plate III. There are other broad margins shown in Plates V and IX.)

The scars of deeper burns were relatively free of pigment but the margins of all burns usually showed an inner light and outer dark zone of pigmentation that represented grades of burning and tanning. The broad margins showed these changes best.

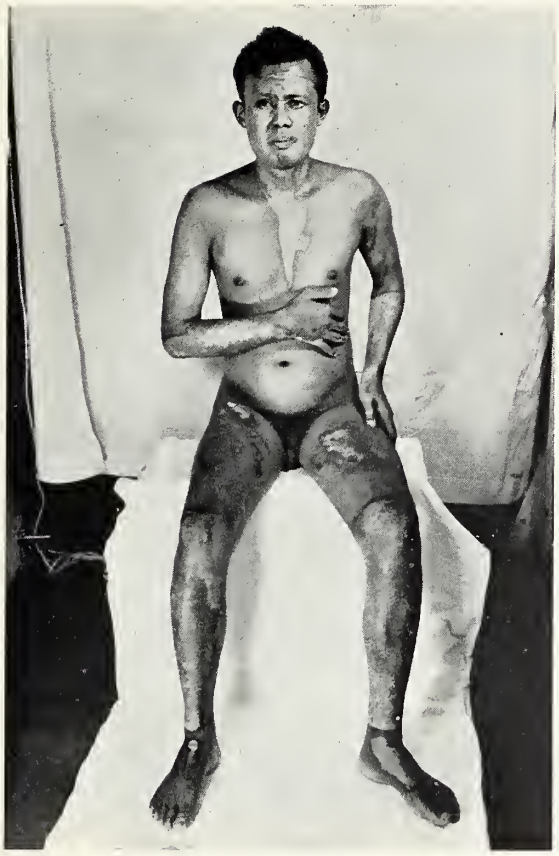


Plate I—Case One.



Plate II—Case One.

Presentation of Cases*

Case One: H. L., age 25. He wore a cap; a shirt with the collar and bosom open and the sleeves rolled up; trousers, reduced to shorts; and shoes.

Pose: Erect and walking in such a way that the rays struck the front and some of the right side of the body.

Nature and Distribution of the Burns: (Plates I, II, and III). There are second and third degree burns on the right side of the face, neck, volar aspect of the left forearm and lateral aspect of the right forearm, and the front and right surfaces of both legs; V-shaped burn of the neck and chest; streak-burns of the fingers; and flame-shaped burns about the left shoulder and arm, over the dorsa of the feet, and beneath the pocket area of the shorts. Much hair is missing at the right temple and the right side of the mustache. The protected zones correspond to the areas covered by the cap, shirt, shorts, and shoes, and to a shadow of the chin at the upper part of the neck. The narrow margins correspond to the edges of the garments and to sharply bent surfaces due to anatomic contours. The broad margins are on less curved and relatively flat surfaces. There is pigment loss in the scars and hyperpigmentation at the margins.



Plate III—Case One

* These cases, as outlined, serve as legends for the plates.



Plate IV—Case Two.



Plate V—Case Two.

Case Two: H. H. D. E., age 25. He wore only trousers and shoes.

Pose: He was erect and faced such a way that the rays struck the left and posterior aspects of the body. (Plate IV.)

Nature and Distribution of the Burns: There are second and third degree burns on the left side of the face, neck, and back, including the left side of the chest as far down as the belt-line of the trousers, the summit and lateral aspect of the left shoulder, the lateral aspect of the left arm and forearm; and flame-shaped burns over the lateral aspect of the left hip. The skin of the scalp is normal. There are normal zones in the shadows of the vertebral border of the left scapula and the prominence of the left lumbar muscle group (Plate V).

Case Three: H. L., age 27. He wore a cap, trousers, and shoes.

Pose: Erect and faced such a way that the rays struck the front of the body from the left. The right forearm and wrist were over the brow and the left arm was held against the chest (Plate VI).

Nature and Distribution of the Burns: There are second and third degree burns of the front and left aspects of the face, neck, chest, and abdomen, as far down as the belt-line of the trousers; the summit of the left shoulder; the anterior surface of the left arm, and medial surface of the right arm; the dorsal surface of the left, and the volar surface of the right forearm and wrists; and streak-burns on the dorsal aspects of the proximal phalanges of the right hand and volar surface of the right thumb (Plate VI). The protected zones correspond to the shadows of the forearms (Plate VII) and to the shadow of the left ear.

Case Four: G. B., age 29. He wore a cap, trousers, and shoes.

Pose: Erect and faced such a way that the rays struck the front of the body from the right. He pressed his right forearm against the upper part of his chest and looked in the direction of the explosion.

Nature and Distribution of the Burns: There are second and third degree burns on the front and right aspects of the face, neck, chest, and abdomen, as far down as the belt-line of the trousers; the summits of both shoulders, the lateral aspects of the right arm and forearm, and the vermillion border of the lower lip. The areas in the shadows

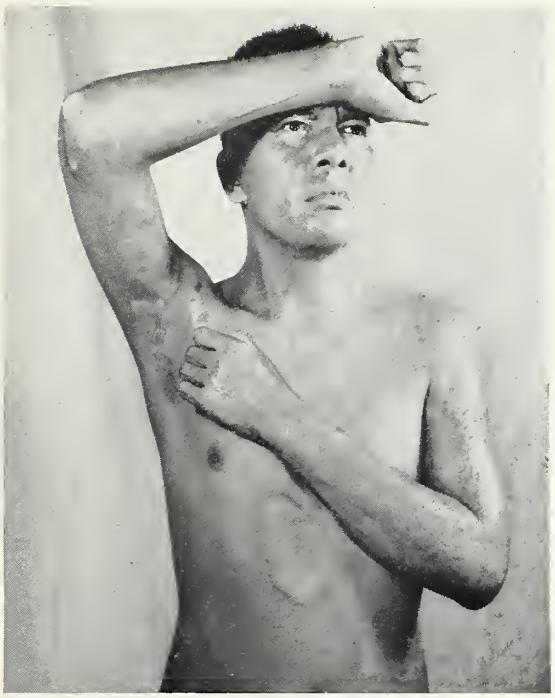


Plate VI—Case Three.



Plate VII—Case Three.

of the visor of the cap, chin, and lower jaw, and the right forearm were protected (Plate VIII). There are broad margins of the burns over the relatively flat surfaces.



Plate VIII—Case Four.

Case Five: V. L., age 23. He wore a cap, trousers, and shoes.

Pose: He was unable to recall it.

Nature and Distribution of the Burns: There are second and third degree burns on the summits of both shoulders that become gradually milder over the subjacent chest wall. The anterior aspect of the face is burned, as well as the lateral surface of the upper part of the right arm. The skin of the forehead was protected by the visor of the cap. The anterior aspect of the neck and a broad zone over the middle of the chest are protected by the shadow of the jaws and head. The margins of the burns on the chest are very broad (Plate IX).

Case Six: A. B. C., age 28. He wore a cap, shorts, and shoes.

Pose: He was pushing a cart and the rays struck the left side of the body from behind.

Nature and Distribution of the Burns: There are second and third degree burns on the back, as far down as the belt-line of the trousers, lateral aspect of entire left arm, left and posterior aspects of the neck, the summit of the left shoulder, the lateral aspect of the left leg and the medial aspect of the right leg. There are protected areas in the shadows of the vertebral border of the left scapula and prominence of the left lumbar muscle group.



Plate IX—Case Five.



Plate X—Case Seven.

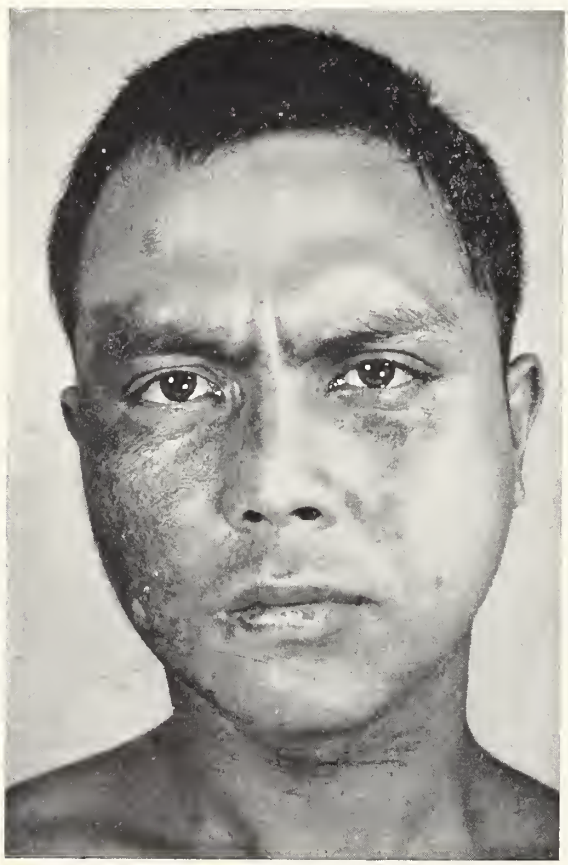


Plate XI—Case Nine.

Case Seven: O. v. d. B., age 22. He wore a cap, shirt with open collar and sleeves rolled up, trousers, and shoes. There was a hole in the left shoulder of the shirt.

Pose: Erect with rays directed into the front of the body.

Nature and Distribution of the Burns: There were second and third degree burns about the front of the face and left ear. The upper half of the ear is deformed by scarring. The anterior aspect of the lower part of the neck, the summit of the left shoulder, and the volar aspects of the forearms show healing third degree burns, with early contractures. Small flame-shaped areas are present over the anterior surfaces of both arms (Plate X). The forehead was protected by the cap.

Case Eight: J. A. M., age 32. He wore a cap, shirt with open collar and sleeves rolled up, trousers, and shoes.

Pose: The rays were directed into the front of the body as he was carrying scrap.

Nature and Distribution of the Burns: The face, neck, volar aspect of left forearm, and summit of right shoulder show second and third degree burns. There are streak-burns of the dorsa of the fingers.

Case Nine: R. B., age 25. He wore a cap, shirt with the collar and bosom open, trousers, and shoes.

Pose: He was pushing a cart in such a way that the rays were directed into the right side of the body.

Nature and Distribution of the Burns: There are third and second degree burns on the right side of the face. The vermillion border of the lower lip is burned and there are streak-burns on the dorsa of the fingers. Flame-shaped burns are present over the right flank and back. The forehead was protected by the cap's visor, and the nasal side of the left cheek by the nose shadow (Plate XI).

Conclusions

Rays from the activated atomic bomb produced first, second, and third degree thermal burns of the skin.

The distribution of the burns was influenced by the position of the body and the wearing apparel of the victim at the time of exposure.

The depth variations of the burns on a given area of the body were correlated with the surface anatomical features and the incidence of the rays.

The parts of the body covered by the fabric of the wearing apparel were generally protected. Long, thick hair protected the scalp but short hair did not protect the temples or less hairy portions of the face.

There was no hematological evidence of injury to the blood-forming tissues in these patients.

ONE STAGE RESECTION OF LEFT COLON LESIONS WITHOUT COLOSTOMY*

Karl A. Meyer, M.D.†

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CHICAGO

THE right and left half of the colon not only has differed in its anatomy, physiology, and pathology, but until recently in its surgical treatment, as well. For, whereas resections of the ascending colon with an immediate anastomosis of ileum to transverse colon has been an accepted procedure, the treatment of lesions of the left side of the colon has consisted of exteriorization procedures producing a colostomy at the site of resection or proximal to it. The latter concept was held on the following grounds: (1) the blood supply of the colon is inadequate for primary anastomoses; (2) the bacterial flora of the colon leads to a formidable incidence of peritonitis and wound infection, and (3) distention of the colon postoperatively would lead to a rupture of the suture line. Many recent developments have occurred which necessitate a reevaluation of this type of teaching.

Actually, the blood supply of the colon is more adequate than is generally appreciated. Dixon has pointed out that a very free anastomosis occurs between the superior, middle, and inferior hemorrhoidal arteries. Ligation of the superior hemorrhoidal artery can be performed without loss of viability of any portion of the pelvic colon. If the branches of the inferior mesenteric artery are ligated at the point of division of the mesentery and not beyond it, and the mesentery is not stripped from the colon for more than a centimeter from the line of anastomosis, necrosis from lack of blood supply need not be feared. Singleton has called attention to the blood supply provided by the epiploic fat which can be utilized. Lesions of the splenic flexure of the colon should offer still less of a problem, for some reliance can be placed on obtaining blood supply from branches of the right colic artery.

Bacteriologically, the colon should no longer offer a challenge—with the advent of the modern chemotherapeutic era. With the availability of at least three drugs to reduce effectively the count of coliform organisms in the stool (succinylsulfathiazole, phthalylsulfathiazole and streptomycin) the colon can now be rendered non-pathogenic from a bacterial point of view. Succinylsulfathiazole will furthermore reduce the bulk of the stool and the quantity of gas in the colon, both desirable features in the preparation of the colon for operation. The teaching of Coller that it is not the spillage at the time of operation that produces a fatal peritonitis but the soilage from a persistent leak at the suture line supports our point of view as to the danger of peritonitis following colon surgery. If then, finally, one utilizes penicillin and sulfadiazine within the peritoneum and parenterally after operation, the most serious objection to direct methods of colon suture should vanish. Certainly the sword that hung over the heads of the surgeons at the time Mikulicz and Block popularized the procedure of exteriorization should no longer be heeded.

It is now firmly established that the bulk of intestinal gases come not from fermentation or diffusion from the blood stream, but from swallowed

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atmospheric air. If the entry of atmospheric air, then, can be prevented one should have the problem of distention controlled. Actually, this can be done readily with intragastric suction maintained by the use of a Levine tube of good caliber. In our hands, this method of decompression has proved so effective we have not resorted to the use of a Miller-Abbott tube, cecostomy, or colostomy for decompression. The use of succinylsulfathiazole which decreases fermentation in the colon, and preoperative cleansing of the colon with enemata, have all aided in the prevention of postoperative distention. We feel, therefore, that the fear of a "blow-out" at the suture line is sufficiently remote so that it need not deter us from our decision to perform an immediate anastomosis and return the colon to the peritoneum.

Having answered the three aforementioned objections to primary resections of the left colon, there exist at least three peculiarities of left-sided lesions which we believe further support this newer surgical approach:

The first peculiarity of left colon lesions is the vulnerability of the colon to early onset of symptoms compared to the right half of the colon. The function of the left colon is primarily that of a storage chamber, fecal matter is dehydrated and formed there. The circumference of the left colon is much less than the right and is less distendable. Further, almost all lesions of the colon are annular and produce sufficient fibroplastic reaction to produce stenosis of the lumen. All of these features combined lead to the earlier manifestation of symptoms. Because the majority of left colon lesions are also ulcerating adenocarcinomas, bright red blood in the stool is a symptom in at least 80 per cent of these patients, which usually leads them to seek medical consultation relatively early.

Although patients with lesions of the left half of the colon present themselves more often with the complaint of melena than do patients with lesions of the right half of the colon, it is the latter group who have the more severe anemia. The reasons for this are not well understood, but the clinical observation has been often confirmed. From a nutritional point, it has been our experience that the patients with right-sided lesions do not fare as well. They show a greater average weight loss, asthenia, and anorexia, in a good measure due to the more prolonged course of their disease. In other words, we believe that the patient with a left-sided lesion presents himself in better physical condition, has less anemia, less malnutrition, and will require less preoperative preparation. With the exception of those who obstruct, these patients should therefore withstand their resection best.

A third peculiarity that is characteristic of left colon neoplasms concerns certain pathological observations. Probably because of their earlier recognition, these lesions show at the time of operation a lower incidence of regional extension and lymphatic spread, and a lower grade of malignancy on the basis of histological criteria. Furthermore, when these lesions do involve the regional lymph nodes they spread upward and not downward. This was first emphasized by Gilchrist and David and recently reaffirmed by Glover and Waugh. This implies that if at least two centimeters of bowel below the lesion and all of the gland-bearing mesentery normally draining that segment of colon is removed, together with the lesion, the chances of overlooking a retrograde metastasis of the neoplasm is indeed slight. It is with this knowledge that most surgeons have had the courage to adopt the procedure of resection and anastomosis for the rectum and sigmoid rather than the classical abdomino-perineal resection.

Preoperative Requirements

Despite these favorable clinical features of left colon lesions, we still would not be undertaking primary resections and anastomoses of that segment of bowel had it not been for the introduction of a series of contributions to the care of surgical patients. We feel these have been indispensable to the success of this procedure and we shall cover them in the order of their importance.

Succinylsulfathiazole. We have appreciated this drug to its full extent and did not depart upon this particular surgical procedure until it was available. With few exceptions we have deliberately avoided proceeding with a primary colon resection where the patient had not been prepared with this drug; the exceptions usually were errors in diagnosis and the situation demanded that something be done.

We have insisted upon at least one week's administration of the drug, in doses of 12, 15, or 18 grams per day, depending upon the body weight of the patient. A thorough mechanical cleansing is usually done at the commencement and conclusion of therapy. At the time of the latter, we have more recently resorted to enemas containing succinylsulfathiazole as recommended by Poth. Although phthalylsulfathiazole can be administered in half the dose, it does not have the same favorable effect upon the contents of the colon. We are looking forward to the use of streptomycin for sterilization of the colon but as yet it is not available in sufficient amounts to warrant its use for that purpose.

Blood Transfusions. We have previously reported our reasons for preference of whole blood to any other protein containing fluid for the preparation of patients for operation. Briefly, these were: a more rapid effect upon the raising of circulatory protein levels, the provision of both plasma and hemoglobin as protein metabolites, and the inclusion of many immunological factors concerned in the resistance to infection. We frequently have seen a sense of well-being produced following blood transfusions but not after other protein-containing fluids. Although patients with lesions of the left colon do not require as much blood to correct anemia as do patients with right-sided lesions, nevertheless we have insisted that each of these patients receive a minimum of 2,000 cc. of blood before and during the bowel resection irregardless of the admitting

blood count. We have learned to appreciate the value of amino acids in correcting tissue protein deficiencies and use them in conjunction with blood transfusions; we believe we achieve a better effect upon blood proteins by that means than by the administration of either solution alone. With such preparations (carried out simultaneously with succinylsulfathiazole therapy) we have been quite impressed with the infrequent occurrence of shock during or after the surgical procedure. We never have seen any sequelae from such liberal use of blood transfusions even though we thereby have produced erythrocyte counts above 6,000,000 and hematocrits well above 50 per cent.

Diet. The use of a low residue diet containing 100 or more grams of protein and 500 or more grams of carbohydrate is important. The administration of such quantities of food usually is done best with six feedings per day. The oral route should be taken advantage of whenever possible as the method of choice for the administration of protein. With the exception of the small percentage of patients who present themselves with obstruction, and these can be fed after colostomy, all of these patients usually can tolerate such a diet. The administration of such quantities of protein from natural foods can be a challenge. Because of this, oral protein digests have been made available. We reported elsewhere on the efficacy of this approach to the problem of protein nutrition. Such protein digests lend themselves rather well to diets required by patients with colonic lesions for they provide little bulk, are highly digestible, and do not have a laxative effect upon the colon.

Vitamins. A specific need exists for vitamin B-complex for its role in carbohydrate metabolism and for ascorbic acid for its role in wound-healing. Neither of these vitamins are stored and in all likelihood the increased metabolism produced by the presence of a colonic lesion, especially if there is diarrhea, calls for an increased intake. Because the preoperative period for correction of such vitamin deficiencies is rather short, it is recommended that they be given along with the parenteral fluids as well as orally.

Enemas. These are administered the day preceding surgery and are repeated until the return is absolutely clear. The presence of stool at the suture line can lead to disastrous complications and every effort must be exerted to assure a mechanically clean colon when the patient comes to the operating room. More recently we have followed Poth's suggestion in the use of enemas containing 6 grams of succinylsulfathiazole and 10 grams of sodium bicarbonate to the quart of warm tap water. These can be repeated until the return is clear. Although the bacteriological effect of such an enema is not known, it is well-tolerated and offers certain theoretical advantages over other enemas.

Surgical Technique

Since our initial report of twenty patients with lesions of the left colon treated by primary resection without complimentary colostomy, in November, 1945, my associates and I have operated at least thirty-two additional such patients. There have been no further fatalities since the first death initially reported and attributed to pulmonary embolism. A mortality rate of 2 per cent for this procedure is low but has been equalled by others (Wangensteen, Waugh). Equally remarkable is a very low morbidity rate, largely attributable to rather painstaking preoperative and postoperative care. There are, however, many operative principles we feel important enough to be discussed at this point.

Spinal Anesthesia. With few exceptions all of our resections were carried out under spinal anesthesia. This we feel has offered us optimal relaxation, a quiescent, contracted gastrointestinal tract, and a conscious patient with a good cough reflex with which to expectorate. The amount of nursing care required for spinal patients is considerably less than for operations of equal length under inhalant anesthesia. With the use of long-acting intrathecal drugs, such as pontocaine-dextrose or nupercaine, we have had adequate anesthesia time without recourse to inlying spinal needles. In the case of an apprehensive individual or one who has sensory complaints before the completion of the operation, the use of intravenous sodium pentothal has proved to be a distinct aid.

Incision. A left paramedian incision has been used almost routinely for lesions of the left colon, made either above or below the umbilicus depending upon the exact level of the lesion. This incision permits adequate exposure and exploration for local as well as distant metastases. The visceral peritoneal reflections are then dissected free to permit mobilization of the involved segment of bowel. In a lesion of the sigmoid the sigmoidal branches of the inferior mesenteric artery are ligated and the superior hemorrhoidal artery maintained. However, in a lesion lower in the pelvic colon the latter vessel can also be sacrificed without fear of loss of bowel viability.

Resection. We have used the method of "open" resection in preference to "closed" methods for we believe they are simpler and less cumbersome than with the variety of clamps required by the latter method. We do not believe peritonitis is any longer a serious consideration. On the other hand, we fear the use of crushing clamps which may lead to necrosis and a leak many days later which we feel is more likely to lead to peritonitis.

Sulfanilimide or sulfadiazine has been applied topically to the suture line. An end-to-end method of anastomosis is employed, using interrupted sutures on atraumatic needles throughout. Straight intestinal forceps are left on only long enough to place guy sutures to align the proximal and distal segments. The angle stitch is placed so that the knot lies on the inside of the bowel lumen. The mucosal row of interrupted sutures is then completed, using fine chromic catgut. This is continued

on the anterior surface without any effort at this time to invert the mucosal edges. A second seromuscular row of sutures on both the posterior and anterior surfaces is then placed, using a permanent suture material such as stainless steel wire or silk. Finally, the rent in the mesentery is closed with interrupted sutures. We feel the use of interrupted sutures has less of a narrowing effect upon the bowel lumen and does not place too much reliance upon a single strand of suture material.

Wound Closure. All wounds have been closed without drains. The peritoneum has been closed with interrupted fine silk placed closed together. The fascia is closed similarly, using No. 32 stainless steel wire, and the skin is also closed with interrupted sutures of silk or dermal. This type of wound closure is more time-consuming but it provides excellent security. We have had no instance of wound evisceration with this method of closure, and wound infections and stitch abscesses have been minimal. This method of wound closure also facilitates our program of early ambulation, which we shall discuss later.

Postoperative Requirements

The efforts devoted to the patient up to this point, although considerable, are not enough. Unless an equally carefully planned postoperative course is assured the ultimate mortality and morbidity rate will be increased. A few of the more important measures are the following:

Gastric Suction. This is maintained by an inlying Levine tube attached to a Wangensteen suction bottle apparatus. The tube is passed before the patient is taken to the operating room and continuous suction is established from that time on until the signs of peristaltic activity are apparent, which usually occurs after the third postoperative day. All siphonage material should be collected and measured and if it exceeds the quantity taken per os or tube, it is calculated into the patient's saline requirements for the next day. The patient is encouraged to drink immediately upon return from the operating room. This irrigates the Levine tube and makes it more tolerable, promotes oral hygiene, and prevents a parotitis.

Parenteral Fluids. A minimal quantity of 3,000 cc. of fluids per day is administered during the period the patient is on gastric suction. This quantity should be increased if there is undue loss due to gastric suction, perspiration, or if the patient excretes less than 1,000 cc. of urine per day. Ordinarily, not more than 1,000 cc. of this fluid regimen consists of saline; we frequently also give 1,000 cc. of an amino acid solution intravenously, as well as a liter of sodium lactate, or its equivalent, to alkalinize the urine during chemotherapy. With the quantity of blood administered preoperatively, we rarely have had to transfuse these patients postoperatively, but if the occasion demanded it, there would be no reason to hesitate to do so. It must be remembered to record blood transfusions in the daily fluid intake as saline.

Chemotherapy. The oral administration of succinylsulfathiazole preoperatively and the topical use of sulfa drugs at laparotomy is followed by the intravenous use of sulfadiazine for at least the first three postoperative days. Five grams or less of the drug per day is usually sufficient to maintain a blood level between 8 and 12 milligrams per cent. We have not routinely administered succinylsulfathiazole postoperatively for the patient has an intragrastric tube for three days and then usually is not ready to ingest the number of tablets necessary to give an adequate dose of this drug; moreover, we are not convinced that the drug is necessary at this time. We have not employed penicillin routinely but we do so when some respiratory or other complication may threaten. The low febrile course in these patients is quite remarkable.

Oxygen and Hyperventilation. In patients whose condition is precarious, in the aged, or those with cardiac complications, oxygen per B.L.B. mask or nasal catheter is employed for at least the first twenty-four hours.

Although 100 per cent oxygen has an acknowledged position in the treatment of distention, we have not had to resort to it for that purpose, for the Levine tube inserted preoperatively has been effective. All of our patients are hyperventilated immediately postoperatively, using mixtures of carbon dioxide and oxygen, until hyperpnea develops or the patient coughs. This is just as important in patients having received spinal anesthesia for they are just as apt to develop pulmonary complications.

Early Ambulation. All of these patients are requested to get out of bed and sit in a chair for fifteen minutes twice on the first postoperative day. The intervals are increased by fifteen minutes each day thereafter, so that by the fifth or sixth day these people frequently are walking in the corridors. We have employed this practice in a large variety of surgical patients since 1939 and believe there are many advantages. Among these are: fewer pulmonary and vascular complications, better wound healing, fewer catheterizations and enemas, earlier return of appetite and strength, lower and shorter febrile courses, fewer hypodermics of morphine, and less nursing care. This particular subject will be covered in greater detail in a separate report.

Diet. This usually commences the day the Levine tube is withdrawn and on that day consists of clear liquids in quantities of 2 ounces every hour. If that is well tolerated, small frequent feedings of low residue foods are given on the following day. By the time of discharge the patient should be eating a regular diet. Vitamins are administered

orally along with the diet (they are given with the parenteral fluids prior to that time). Laxatives are avoided, but if an enema is required this can be safely administered after the fifth postoperative day.

Discussion

Earlier in this presentation we discussed why lesions of the left half of the colon were suitable for the type of surgical procedure we have described. We have deferred, to this point, any mention of the advantages of this procedure over others previously employed. Briefly, these are as follows: (1) A more adequate removal of bowel and lymph-bearing tissue can be done for no tissue has to be spared for the development of a proximal and distal loop in an exteriorization operation. (2) The complications of exteriorization operations can be avoided, viz., retraction of one or both loops, wound infection, prolapse, herniation, fecal fistula, obstruction, and stricture formation. (3) A colostomy can be avoided, even a temporary one. (4) Elimination of return visits to the hospital and follow-up operations for crushing of a septal spur or closure of the colostomy. The economic saving is considerable.

It would not be fair to close this discussion without mention of certain conditions which we feel are contraindications to this procedure. Obviously, a patient with a distended colon due to obstruction should have only a colostomy done at that time for decompression; if this is planned far enough proximal to the site of the lesion a subsequent primary resection and anastomosis as outlined here can be done later, with closure of the colostomy as a third step. If the lesions have perforated and produced a fistula, abscess, or peritonitis, a one-stage resection in the presence of such inflammatory reaction would be ill-advised. Lesions which lie 10 centimeters or less from the pectinate line should be accurately appraised for size, fixation, and regional extension to insure adequate removal of cancer-bearing tissue; it would still be in the best interests of the patient in the equivocal case to err on the side of performing an abdomino-perineal procedure. Finally, one is occasionally obliged to operate on an obese patient with a mesentery so fat and short that adequate approximation of the resected loops with tension is difficult; in this type of case, too, a primary resection and anastomosis may not be the operation of choice.

OCCUPATIONAL ADJUSTMENT OF PSYCHONEUROTIC VETERANS*

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THE future adjustment of veterans who have been discharged from the service for psychoneurotic conditions has been the subject of discussion in lay and professional articles. The writer has had an opportunity to collect material that in part may give an answer. The source of this material consists of histories taken on several hundred veterans seen in private practice and as a designated psychiatric examiner for the Veterans Administration. These veterans were all discharged from service on disability basis for some type of psychoneurosis. Only the occupational adjustment will be discussed in this paper. Geographically these veterans came from the environs of Fort Wayne and Northeastern Indiana. Office, rural, industrial, and urban workers are represented.

Of some 218 veterans who were discharged because of a neurotic illness, all but 16 had gainful occupations before service. Sixteen veterans, or 8 per cent, went directly from high school into service. Time at examination did not permit any exhaustive inquiry into the type of pre-service vocational adjustment. A big percentage had jobs definitely related to the war effort. In peace time many of these men would have been in school. Also, many more would have been in less strictly industrial assignments. The title of the pre-service position did not necessarily reflect a true ability for that position. Thirty-two per cent held jobs relating to the manufacture of war implements. It was noted that a small number left school to work because of the stimulus of high salaries and ease of getting work. The knowledge that they would be drafted soon influenced many high school graduates to postpone college and to work in the interim.

Figures alone do not tell the story of the occupational adjustment of the psychoneurotic veterans. However, the percentages furnish food for thought. The interval of time between discharge and actual

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return to work might be used as a gauge for the severity of symptoms. Thirty-five per cent rested from one to two months before seeking gainful occupation. This interval was spent in reorientation in the neighborhood, travel, pleasure pursuits, plans for marriage, visits to private doctors for functional complaints, and a few frankly admitted heavy indulgence in alcoholic beverages in search of relief from tension. Seventeen veterans rested for six months or more. Several did no gainful work for one year.

The number of jobs since discharge reflected insecurity. Fifty-two per cent have held but one job and 13 per cent have had three jobs. There were three veterans who had seven or more different jobs. One veteran led the list with twelve different positions.

Delving into the vocational adjustment further, it was apparent that the time spent in resting after discharge and the number of jobs held did not tell all of the story. A study of the amount of time lost from work because of functional complaints was revealing. Having held but one or two jobs since discharge did not necessarily indicate satisfactory work adjustment, because these veterans may have lost much time from work. Fifty-five per cent were away from work 10 per cent or less of the possible working time. There were twenty veterans who have worked but 50 per cent of the time. There was definite correlation between work stability and interval of time since discharge. This was reflected in more time at duty and less job changes. In general, the intensity of neurotic symptoms had diminished or a position had been obtained that was more compatible with their condition. It is believed that either one of these factors explained the satisfactory work adjustment at the time of the examination. A closer check of the histories revealed that 17 per cent, or thirty-nine veterans, had lost no time from work. Many of these had held but one job since discharge.

Vocational adjustment may be reflected in the frequency with which veterans have returned to their former work and employers. Inquiry into this aspect showed that seventy-five veterans, or 34 per cent of the two hundred eighteen, were holding the same pre-service job to the present time. Many of these were also in the same group who lost no time from work because of functional complaints. The remaining one hundred forty-three have had one or more jobs different from their pre-service vocational work. There were thirty-seven veterans who returned to their former jobs but were unable to do the work and sought other positions.

Seemingly this group has not been interested in the educational advantages offered to veterans. Only five of those two hundred two who had gainful occupations prior to service sought to further their education. Interesting, however, was the fact that five of the sixteen who had been in school prior to service sought to finish their education. It would appear that this group of two hundred eighteen veterans, as a whole, lost any pre-existing desire for formal education.

For the purpose of this paper occupational adjustment is defined as holding a job at the time examined, regardless of any other discussed factors. One hundred and sixty-three veterans held formal jobs at the time examined. Thus, thirty-nine gave various reasons for unemployment. Some of the reasons were: resigned merely to rest; dissatisfaction with salary; dislike for assigned work; arguments with superiors; actual discharge from the job; physical illness and neurotic complaints; and a sincere belief that they were incapable of work.

The present day ease with which jobs can be obtained has afforded these veterans the opportunity to shop around for jobs they think they are capable of handling. The reasons given for quitting jobs were varied and multiple. Low fatigue threshold, irritability, noise sensitivity, backache, and feelings of confinement led the list of expressed reasons.

Easy fatigue was a frequent reason. Such a reason was reflected in such remarks as "too long hours," "couldn't take it," "I just don't have the pep I used to." Many quit early in the day, some reported to work only two-thirds to three-fourths of the time, and others requested leaves of absence of a week's length. Many stated that week ends were a blessed relief.

Irritability led to frequent arguments, accusations of discrimination in assigned work, and resignation—if not dismissal. On close questioning, the veterans would admit that the trouble was within themselves. Many would later apologize for their emotional outbursts. They were unable to understand fully their irritability. Some were reminded of an arrogant non-commissioned officer. Some protested regimentation reminiscent of the Army. One veteran, in a shame faced manner, admitted that he had been responsible for a baby riot in one small plant.

As frequent as any complaint given for changing jobs was that of noise. It was not uncommon, in taking histories, to find that a veteran would last but one day in a plant because of noise sensitivity. Many sought outdoor or non-industrial jobs, as a result. Anger over horseplay with steam and air lines would be recounted. Some fellow-worker would make a screeching noise with such lines in order to see the startle pattern of some veteran who had been in combat. One veteran stated the only reason he was not in prison for manslaughter was the fact that his aim with a pop bottle was a poor one. These veterans so afflicted with a startle pattern stated that their act of retaliation was instantaneous and automatic. Because of possible dire consequences they feared these instantaneous retaliatory acts.

Backache led many to quit their jobs as truck drivers or any job involving long standing. The complaint of backache due to heavy lifting was fre-

quent. Those who persisted with their jobs in spite of backache resorted to numerous remedies and dispensary visits.

The open, outdoor life while in service led to discomfort for some when resuming indoor civilian work. It is believed that for most such veterans the contrast was a little too great to handle as an abrupt change, rather than a simon-pure claustrophobia. "Give me the open space," was a common remark. Possibly military taught rules for avenues of escape or safety led to indoor discomfort.

Those who did not sever their connections with their employer asked for reassignment or sought shorter hours at sacrifice of pay or seniority. Those working indoors asked for outdoor tasks. Those at desk office jobs asked for roving maintenance assignments. Others, in a noisy factory, would ask for office work. All permissible rest periods were utilized. Seemingly the pre-service type of occupation did not bear any relationship to present discontent. Many admitted frequent trips to the factory dispensary. Others cut down off-work activities to a minimum in order to conserve strength for the coming work day.

Very few men were using any service learned skill. One veteran had risen to a chief of a department in an auto plant on the basis of a service acquired skill. Ten veterans expressed a wish that they were back in service. Five actually had been rejected upon attempts to re-enlist. Seemingly, these individuals were attracted to the every day security that the military service offered. It was interesting to observe that a few veterans who were pure culture neurotics were making excellent work adjustments; however, the personal life was stormy and it appeared that they were using their work as an emotional outlet. Some showed apprehension lest they lose their pensions before they could become settled in a satisfactory occupation. Many frankly expected to have their pensions reduced. This possibility increased the basic anxiety when the work record was poor. Work history alone did not reflect the chaos and torment in the personal lives of these veterans. Some veterans were already apprehensive as to their working ability when the demands of industry would become more stringent. A few veterans admitted being at a loss because there was no longer the group identification they had known in the services. Delayed anxiety reactions were seen. By this term is meant those who had been in combat, received a non-medical discharge, and after several months at work developed anxiety reactions that were incapacitating.

In those veterans who sought help for their complaints through psychotherapy it was interesting to observe that a better work record paralleled or even preceded the general clinical improvement. Gradual increase in the hours worked, better concentration, and less fatigue because of lessened emotional drain were early signs of improvement. Some sought help because of indecision as to the type of work they were best suited for. Others wanted help in the decision to attempt college. A few seemed to realize that the amount of work they did could not explain all of the fatigue they were experiencing. One is reminded of the articles in the literature pertaining to the use of psychiatry in industry.

In summary, the following observations were made in this group of veterans discharged from the military services for neurotic conditions:

1. The usual time spent in resting after disability discharged was a period of one to two months.
2. Over 50 per cent have held but one job since discharge.
3. Fifty-five per cent were away from work 10 per cent or less of the possible working time.
4. Seventeen per cent or thirty-nine veterans lost no time from work.
5. Thirty-four per cent were holding the same pre-service job.
6. Only five of those who were gainfully employed before service were in college at the time examined.
7. Low fatigue threshold, irritability, noise sensitivity, backache, and feeling of confinement were the principal reasons given for job changes.
8. Those who persisted with the same employer requested shorter hours or different assignments.
9. The work record did not reflect the chaotic personal life of some of these veterans.
10. Those who sought help through psychotherapy reflected an early improvement by a more stable work record.

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CASE OF GLOMUS TUMOR

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THE glomus is a normal structure of the skin and subcutaneous tissue. It is a shunt between the peripheral, arterial, and venous systems. It is intimately connected with the sympathetic nervous system. Most authors agree that it is a part of the heat regulating system of the body and may play some part in the regulation of blood pressure. Popoff[1] says, "The function of the glomus is to control the arteriovenous circulation in the digits and to regulate both the local and general temperature of the body." Bergstrand[2] says, "The glomus is a peculiar structure combining some elements of nerve tissue, vascular tissue and muscular tissue." Any disturbance therefore presents a clinical syndrome pertaining to all these systems. The glomera are most numerous in the hands and feet. The blanching of the skin of the hands and feet when exposed to cold is probably due to the function of the glomus instead of the capillaries. The blood is probably shunted through the numerous glomera and excluded from the capillaries, thereby conserving heat, similar to the thermostat on an automobile engine.

Blanchard[3] says, "The glomus is a skein or conglomeration of small anastomotic channels which is supplied by an afferent arteriole. This afferent arteriole is in turn a branch of a preterminal cutaneous artery. The anastomotic channels rejoin one another to form a collecting venule. Surrounding the skein and running in between the individual channels, is a fibrous reticulum in which are a number of non-myelinated nerve fibres and small capillaries. The anastomotic channels differ from the arteriole from which they arise in that they do not possess an internal elastic lamina. They are lined with a single layer of endothelial cells which may be flattened or cuboidal. External to the endothelium there is an inner circular and an outer longitudinal layer of smooth muscle." In this external layer are found the so-called "glomus" cells or "epithelioid" cells. These cells are fairly large, have rounded, slightly vesicular nuclei and rather pale staining cytoplasm. These cells are regarded by some authors as angioblasts, while others consider them to be specialized neuromuscular cells.

The glomus tumor is an enlargement or overgrowth of this highly specialized arteriovenous anastomosis. The tumors are small, usually not more than a few millimeters in diameter. They present a characteristic color, varying from deep pink to purplish. Since the glomera are more numerous in the extremities, especially in the fingers and toes, their location is chiefly in these areas. Approximately 30 to 40 per cent are found beneath the nails. They are for the most part considered benign, although one or two cases have been reported as showing infiltrating characteristics. The tumors are usually single, but cases of multiple tumors have been reported. Plewes[4] reports four tumors in one finger. Adair[5] reports four in a forearm. Stout[6] reports two cases of multiple tumors around the heel. Bergstrand[2] reported two cases of multiple tumors of the foot. One of his cases had received no relief from periarterial sympathectomy and ramisection, but was completely relieved by the removal of six small tumors.

The outstanding characteristic symptom is pain. The patient may complain of pain in the entire extremity, aggravated by slight trauma or by temperature changes. There seems also to be a disturbance in the excretion of perspiration; usually there is excessive perspiration in the extremity involved.

The treatment consists of simple excision. Cases of long standing are sometimes not entirely relieved immediately.

Case Report: M.S., white male, age thirty-six, seen first January 5, 1945. His chief complaint was pain in the right index finger, of a stinging character, radiating to the elbow. The onset was about August, 1944. There was no definite history of injury. However, he was in the United States Navy, working on marine engines, where his fingers received numerous slight injuries. He described the pain as a stinging pain in the finger and an ache in the entire hand and forearm. The pain was increased by slight trauma or by heat. He claimed he got some relief by immersing the hand in cold water or by placing the hand on the iron bedstead during the night. He also stated that drinking a bottle of cold beer sometimes relieved the pain. During his stay in a Naval Hospital "hot soaks" were used, also "alternate hot and cold baths to improve the circulation." None of these measures improved the condition. He was given the diagnosis of anxiety neurosis and finally discharged from the Navy.

1. Popoff, W.: *Arch. Path.* 18:298. 1934.
2. Bergstrand, H.: Mult. Glomus Tumors and Cancer. 29:470. 1937.
3. Blanchard, A. J.: Path. of Glomus Tumor. *Canadian Med. Assn. J.* 44:357.
4. Plewes, B.: *Canadian Med. Assn. J.* 44:364. 1941.
5. Adair, F.: Glomus Tumor, Clinical Study of Ten Cases. *Am. J. Surg.* 1:6. 1934.
6. Stout, A. P.: Tumors of the Neuro-Myo-Arterial Glomus. *Am. J. Cancer.* 24:255. 1935.

Examination: Both hands were moist. There was normal pulsation in the arteries. The skin of the terminal phalanx of the right index finger was blanched. Just under the anterior edge of the nail, an irregular, dark pinkish mass could be seen. It seemed to be about to protrude from beneath the nail. The anterior half of the nail had a darker color than normal. The slightest touch to the nail or to the finger tip caused him to wince and cry out with pain. During the examination he held the right hand tightly within the left, expressing fear and apprehension. A diagnosis of glomus tumor was made. At operation the anterior two-thirds of the finger nail was lifted and excised. The nail bed presented a dark red, rather granular appearance. No definite outline of the tumor was discernible. The entire exposed part of the nail bed was excised in toto.

Immediately after the operation the patient was free from pain. His general attitude was completely changed from a seemingly severe neurotic individual to a calm and normal behavior.

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ELECTROCARDIOGRAPHIC DIAGNOSIS AND PROGNOSIS OF RECENT CORONARY THROMBOSIS OR OCCLUSION

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THE subject of diagnosis and prognosis of acute coronary thrombosis or occlusion has become of increasing interest to me, because the condition is found more frequently in Negroes than is reported in the literature. The reasons might be that we did not recognize the condition or we may have made the diagnosis but failed to publish our cases.

The clinical diagnosis and prognosis of acute coronary occlusion presents an unpredictable and tragic condition rarely encountered elsewhere in medical experience and history.

The terms "coronary occlusion," "coronary thrombosis," and "myocardial infarction," are often employed synonymously, although there are useful differences in their meanings. Coronary thrombosis refers to a special type of coronary occlusion, thrombosis being the final event in the process of occlusion. Myocardial infarction, though a frequent result of coronary occlusion, does not always follow it.

Doctor Hammer, in 1878, made a clinical diagnosis of this disease. Drs. W. P. Obrastozow and N. D. Straschesko, in 1910, and independently, Dr. J. B. Herrick, in 1912, made the first publications that discussed the clinical features which aided in differentiating an attack of coronary thrombosis from one of angina pectoris. It was a long time before this disease was recognized clinically, although the pathological condition was recorded at autopsy. In 1916, Doctor Levine[1] saw two cases of acute coronary thrombosis, both presented the picture of an acute surgical abdomen. In the first case Doctor Levine advised immediate exploration and the surgeon operated. The patient died on the operating table. On postmortem examination acute coronary thrombosis and infarction of the myocardium were found. Several months later Doctor Levine saw the second case, and recalling the above experience, he made the clinical diagnosis of coronary thrombosis, which was confirmed at autopsy.

A few remarks about angina pectoris may be made because the condition is closely associated with coronary occlusion, in this respect; that is, the signs and symptoms depend upon the changes in the coronary arteries. The pain is substernal, differing in severity, duration, and the precipitating factors. The pain in angina pectoris is of three to ten minutes duration, which is brought on by exercise, but sometimes by excitement, a heavy meal, or exposure to cold. The pain is usually substernal or just to the left of the sternum. There is a tendency for the pain to radiate, most frequently to the left shoulder and arm, and occasionally to the wrist and little finger; less frequently to the neck, jaw, teeth, upper abdomen, or to the right shoulder and arm. Frequently the pain will start at one of these points before focusing on the anterior surface of the chest. The intensity of the pain varies from a slight sense of heaviness to a severe crushing pain. Since the precipitating cause is commonly exertion, rest usually causes the pain to subside. The diagnosis depends upon the history. The physical findings and changes in the electrocardiograph are negative.

1. Levine, Samuel A.: *Clinical Heart Disease*, Third Edition, p. 105, Philadelphia, W. B. Saunders Co., 1945.

Coronary artery occlusion means sudden, complete obstruction of a coronary artery. The symptoms and signs associated with the attack include severe and prolonged substernal pain, shock, impairment of the first heart sound, and gallop rhythm; occasionally a pericardial rub, a fall in blood pressure, fever, leukocytosis, and a rapid sedimentation rate. Usually there is the characteristic electrocardiographic pattern of coronary occlusion.

Electrocardiography has become an essential part of the methods of the examination of the heart. We must not, however, expect too much from the electrocardiograph. While it has a definite place in clinical practice, it cannot replace other customary methods of making a diagnosis, as some physicians have imagined.

In cases of recent coronary occlusion the value of electrocardiograms definitely have been established. A whole series of changes is produced on the four-lead electrocardiograms. The fourth lead,[2] known as the chest or precordial lead, has come into prominence only recently. Still, sufficient information has been published to give a fair basis for interpreting it, and obscure points are rapidly being clarified. It is often of definite assistance in determining the presence, the location, and to some degree the age of the myocardial infarcts. The published reports of a number of cases in which autopsies were performed furnish additional evidence of the accuracy of the electrocardiographic findings. However, the significance of some details is still undetermined. Some investigators have stressed the contour and direction of the QRS complex; others the changes in the ST segment; still others the contour of the T-wave.[3] In a large number of cases the abnormalities in the three conventional leads are in accord with those in the fourth or precordial lead, but this is not true in all cases. The reason for this is not clear. There may be a number of times when the chest lead is characteristic of infarction, yet the three conventional leads[4] may show none of the classic changes. The reverse may be true; that is, the three conventional leads will show changes characteristic of infarction and the chest lead will be atypical.

Coronary occlusion must be differentiated from acute surgical states of the abdomen, such as gallstones and perforated peptic ulcer. As an example, the pain of gallbladder disease may be in the epigastric area, but tenderness will be localized over the gallbladder area. Usually there is no localized area of tenderness in referred pain of coronary disease. In coronary thrombosis there may be marked distention of the abdomen, but the rigidity of the abdominal wall, as that seen in perforated peptic ulcer, is lacking. There are five other types of heart attacks, namely, angina pectoris, dissecting aortic aneurysm, pericarditis, the heartache of neurocirculatory asthenia, and pulmonary embolism.

In angina pectoris the pain is of shorter duration—from five to ten minutes. Pain may be brought on by effort and may be relieved by rest, by making pressure over the area, or by the use of nitroglycerin tablets 1/150 grain.

Dissecting aortic aneurysms, which occur now and then, generally have much more pain in the back than is true of coronary disease.

It is important to distinguish coronary thrombosis and dissecting aortic aneurysms because of the difference in the prognosis. The coronary thrombosis patient is likely to recover from an attack; he has about nine chances out of ten, no matter how severe the pain is. On the other hand, individuals who have dissecting aortic aneurysms have only one chance out of ten to recover.

Pericarditis, of course, rarely causes sudden pain, making it an emergency, but a few individuals do have such pain. It is important, then, in the examination, to emphasize two points: has there been any angina pectoris before; and second, is there pain on breathing? Pain on breathing is common with pericarditis, but rarely, if ever, is the pain of coronary thrombosis actuated by respiration. A friction rub is often heard early in cases of pericarditis, if heard at all. The electrocardiogram does not always absolutely distinguish pericarditis from coronary thrombosis, although repeated records are invaluable. Following an emergency, an electrocardiogram is essential, however, not only in helping to make a diagnosis but in determining the degree of involvement.

The heartache of neurocirculatory asthenia is at the apex of the heart, over the region of the lower part of the precordium, and to the left. It is an aching sensation and often lasts for hours. It may radiate to the arms and almost always is associated with precordial tenderness. The heartache of neurocirculatory asthenia, strange to say, is associated with tenderness, while on the other hand, in many cases of coronary thrombosis there has been no sensation of tenderness; precordial tenderness is, therefore, a very important clue in distinguishing neurocirculatory asthenia from heart disease or as a complication of heart disease.

Pulmonary embolism probably is more frequently confused with coronary thrombosis than with any other condition, although the acute attack with obstruction of the pulmonary circulation may not cause great distress. Often the pros-

2. Wolferth, C. C., and Wood, F. C.: Electrocardiographic Diagnosis of Cornary Occlusion by use of Chest Leads, *Am. J. M. Sc.* 183: 30, 1932.

3. Wood, F. C., and Wolferth, C. C.: Huge T-waves in Precordial Leads in Cardiac Infarction, *Am. Heart J. M. Sc.* 187: 489, 1934.

4. Wood, and Wolferth: An Electrocardiographic Study of Experimental Coronary Occlusion: The Inadequacy of the Three Conventional Leads in Recording Certain Characteristic Changes In Action Current, *J. Clin. Invest.* 11: 815, 1932.

tration due to pulmonary embolism has been one of the most difficult differential diagnostic problems. There tends to be more dyspnea with pulmonary embolism than with coronary thrombosis, but not always. Sometimes, however, the patient with coronary thrombosis may have acute dyspnea. The same statements apply to cyanosis. Both conditions are associated with, or quickly followed by fever and leukocytosis. The x-ray may or may not be helpful. The electrocardiogram is often the most useful differential diagnostic help in the first twenty-four hours, before any physical signs of infarcts are found. It affords almost conclusive evidence as to which condition exists. One must remember, however, that pulmonary embolism may cause a strain on the right ventricle, and produce thereby changes in the circulation and in the electrocardiogram which might at first glance be confused with evidence of coronary thrombosis, unless one is aware of the characteristic changes which do occur.

I am presenting, for your consideration, twenty cases with electrocardiograms, as follows:

Case I. Mrs. H. M., colored female, aged fifty-three. On December 16, 1937, she had a crushing feeling in the epigastric region, followed by marked dyspnea and fear of death. Auscultation of the heart revealed a gallop rhythm with a systolic and diastolic murmur at the base and apex. Her arterial blood pressure was 160/80 millimeters of mercury. Coarse rales were in the lung bases, and 3 plus pitting edema of the legs. Her urine analysis revealed a 4 plus albumin. An electrocardiogram taken December 16, 1937, revealed that there were cove-plane T-waves in Leads I, II, and III, and a slightly depressed S-T segment in Lead IV. She died October 26, 1938. Duration of life, after attack, ten months and ten days.

Case II. Miss H. B., aged thirty. While in bed at night, on January 9, 1938, she had a sudden attack of misery in her chest, followed by cold sweats and dyspnea. She had been feeling weak for several days. Examination revealed a few defective teeth. There was a systolic murmur at the apex of the heart and the arterial blood pressure was 140/80 millimeters of mercury. Electrocardiogram taken January 9, 1938, revealed that there was a depressed S-T segment in Leads I and II with an inversion of the T-wave in Lead II. In Lead III there was a convex S-T segment, an inverted T and Q-wave. In Lead IV there was an elevated S-T segment with an inversion of the T-wave. The patient has lived for the duration of eight years and seven months, to date.

Case III. Mrs. C. J., aged fifty. On February 25, 1938, after vigorous exercise and being frightened, she had a severe crushing pain which seemed to cut off her breath in the epigastric region (lower end of sternum). The pain radiated to her back. She was nauseated, vomited, and felt weak. She had had several attacks of acute indigestion, dizziness, and headache since 1935. Auscultation of the heart revealed a blowing systolic murmur at the base with a marked A_2 accentuation. She was perspiring moderately. Her arterial blood pressure was 220/190 millimeters of mercury. There were rales in the lung bases. Her Wassermann was positive and there was a trace of albumin in her urine. The electrocardiogram taken February 28, 1938, revealed that there were cove plane T-waves in Leads I, II, and IV, with an upright T-wave in Lead III. She died June 2, 1942. Duration of life, after attack, three years, eight months and eleven days.

Case IV. W. E. B., colored male, aged sixty-three. On April 17, 1938, he became extremely short of breath at 4:00 P.M., and began vomiting, which continued until 11:20 P.M. He was cold and clammy and was short of breath, without pain. He had had a previous attack at a meeting on December 27, 1937. The physical examination revealed an ashen color, a slightly clammy condition of skin, and many defective teeth. His temperature was 99 F. and the pulse rate was 80 beats per minute. On auscultation of the heart a systolic murmur was heard at the apex. The sound was of moderate intensity. At the base the first sound was weak and the second markedly accentuated. The arterial blood pressure was 220/160 millimeters of mercury. Extraventricular systoles were heard at the apex. The heart was enlarged to the left. The abdomen was tender in the epigastric region and the liver was palpable. Laboratory findings revealed the urine to be dark red, acid in reaction, specific gravity 1024, albumin 3 plus, and sugar 1 per cent. Microscopic findings were a few red blood cells and threads. His basal metabolism was −14. An electrocardiogram made on April 20, 1938, revealed the following: in Leads I and II there was a convex S-T segment with inversion of the T-wave. In Lead III there was an iso-electric S-T segment and a T-wave. In Lead IV, a monophase QRS complex, a convex S-T segment, and an inverted T-wave were found. The patient died January 18, 1939. Duration of life, nine months and one day, after attack.

Case V. Mrs. L. A. H., colored female, aged fifty-two. On September 3, 1938, she complained of shortness of breath and attacks of indigestion. She complained of dizziness and cramps in her legs for the past ten years. The pain or indigestion attacks, as she called it, radiated up the sternum. Auscultation of the heart revealed that the heart had a systolic murmur at the base with an accentuation of A_2. Arterial blood pressure was 200/90 millimeters of mercury. She died September 10, 1942. Duration of life, four years and seven days. An

electrocardiogram made September 3, 1938, revealed that there was an inverted T-wave in Leads I, II, III and IV.

Case VI. Mr. W. L., colored male, aged fifty, came to the office October 22, 1938, complaining of a severe pain in the left side of his chest which almost cut off his breath. He got slight relief by pressure over his chest. Auscultation of the heart revealed a systolic murmur at the base and apex, and a diastolic murmur at the base. His arterial blood pressure was 130/60 millimeters of mercury and his pulse rate was 120 beats per minute. There were coarse rales and an expiratory wheeze in his chest. He had a positive Wassermann. An electrocardiogram taken October 23, 1938, revealed the following: There was a cove plane T-wave in all leads. The patient died December 12, 1938. Duration of life, two months and three days.

Case VII. Mrs. L. M., colored female, aged fifty-seven. On May 8, 1939, she was complaining of a smothering feeling in the epigastrium, which began four days previously. She had had dyspnea for ten years. Auscultation of the heart revealed a gallop rhythm at the apex. Her arterial blood pressure was 140/80 millimeters of mercury. An electrocardiogram made May 9, 1939, revealed the following: there was an iso-electric S-T segment and an upright T-wave in Lead III. The patient died July 20, 1942. Duration of life, three years, two months and eleven days.

Case VIII. Mrs. M. T., colored female, aged sixty-five. On December 5, 1939, she complained of weakness across her chest. She had had frequent attacks of indigestion. Nine years previously she had a stroke, at the age of forty-five years, and her mother had high blood pressure. There were two sisters who had coronary heart disease. One, reported in this series (case V), died September 10, 1942. Auscultation of the heart revealed a systolic murmur at the base and A_2 was accentuated. Her arterial blood pressure was 210/110 millimeters of mercury. An electrocardiogram taken December 5, 1939, revealed the following: in Lead I, the S-T segment was iso-electric. In Lead II, III, and IV-F, the S-T segments were convex, followed by inverted T-waves. She died July, 1940. Duration of life, six months.

Case IX. Mr. L. H., a colored male, aged forty-nine. On October 14, 1939, he was dizzy and fell. There was twitching of his left hand and tenderness under the calf of his left leg. Auscultation of the heart revealed a systolic murmur at the apex and his arterial blood pressure was 200/100 millimeters of mercury. An electrocardiogram taken October 15, 1939, revealed the following: the blood pressure was 150/90 millimeters of mercury. There was a small Q-wave in Leads I and IV-F and the T-wave was inverted in all leads. His Wassermann was positive. The patient has lived for the duration of six years, ten months and six days, to date.

Case X. H. T. W., colored male, aged fifty-three, was first seen on February 3, 1941. He had been "feeling poorly" for a day or two and on Sunday, February 2, 1941, a severe pain came on suddenly over the epigastrium and radiated over the heart to his left shoulder. Shortly after this he began to vomit. He was in great agony and felt as though he was going to die. A doctor was called, who gave him one "shot" and later, on second call, he gave a second "shot," which gave the patient some relief. The vomiting of greenish and bitter material continued. He had had pain over the midsternum and left shoulder off and on for more than two years. This pain was of short duration. The pain was associated with slight shortness of breath. It would come on at rest and was aggravated by walking fast, walking upstairs, driving his automobile, and at times on taking a bath. He got relief by resting for a short time. His wife stated that he had been starting to work from one to two hours earlier than usual.

Physical examination revealed the following: he had an anxious expression on his face, which was of ashen color, with moderate perspiration. There were a few defective teeth. His temperature was 100 F. and the pulse rate was 110 beats per minute. Auscultation of the heart revealed a presystolic gallop rhythm and a soft systolic murmur at the apex. The sounds at the base were distant and there were no murmurs. His arterial blood pressure was 150/90 millimeters of mercury. The chest was clear. Laboratory findings revealed the urine a dark color, strongly acid, specific gravity 1026, albumin 1 plus, and sugar ¼ per cent. Microscopic findings showed red blood cells 5-10 per high powered field. His Wassermann was 4 plus.

Electrocardiograms were as follows: the first electrocardiogram, on February 8, 1941, showed anterior coronary occlusion. The four leads showed characteristic changes. In Lead I, there was a Q-wave followed by a high take-off of the S-T segment. In Leads II and III a depressed S-T segment occurred. In Lead IV-F the R-wave was absent and there was a high take-off of the S-T segment. His arterial blood pressure was 100/80 millimeters of mercury. The second electrocardiogram, made on February 14, 1941, revealed the following changes when compared with the first one: the S-T segment was more convex with a cove T_1. S_2 was deeper with S-T_2 elevated. S-T_3 was elevated and slightly concave upward and T_3 was upright. The S-T_4 segment was convex and T_4 inverted. The patient has lived for the duration of five years, six months and twelve days, to date.

Case XI. Mrs. I. U., colored female, aged forty-four. On March 30, 1941, she was complaining of vertigo which she had had for five years, and for one year she had had dyspnea and swelling of her ankles. In the course of her disease she developed

severe dyspnea, orthopnea, and edema of her legs, which forced her to go to bed. Auscultation of the heart revealed the apex rate was 120 beats per minute and was irregular. There was a systolic murmur at the base and A_2 was accentuated. Her arterial blood pressure was 240/120 millimeters of mercury. She had rales at the lung bases and edema of her ankles. The laboratory findings revealed the urine had 3 plus albumin and her Wassermann was 4 plus. She recovered and returned to work in six months, but her course was down-hill. After a few months' work she returned to bed again, and again to work, until finally, September, 1942, she went to bed and gradually grew worse, and died July 2, 1943. Electrocardiogram taken April 10, 1941, revealed the following: there was a convex S-T segment with an inversion of the T-wave in Leads I, II, and IV-F with an upright T-wave in Lead III.

Case XII. Mr. W. R., colored Male, aged fifty-seven. In 1942 the patient fell on his job. He had difficulty on urination. He had hot spells, with sweating. He was dizzy and had cramps in his hands and legs. He continued feeling weak. Physical examination revealed that he had many defective teeth. Auscultation of the heart revealed that he had a systolic murmur at the base and a presystolic murmur at the apex, also there was a third heart sound. His arterial blood pressure was 160/90 millimeters of mercury. There was a large tender prostate gland. Laboratory findings revealed that the specific gravity of his urine was 1015. There was a trace of albumin and red blood cells. His Wassermann was positive. After three months rest the patient returned to work. On February 23, 1943, he developed a cough and coughed up blood, with some pain in his chest, and dyspnea. His temperature was 103 F., his radial pulse was 130 beats per minute and his respiration was 40. There was dullness in the right lung. Electrocardiograms taken January 12, 1942, revealed that the S-T segments were convex with inverted T-waves in all leads. The second revealed the following changes: the T-waves were deeper in Leads I, II, and IV-F. The S-T segments were concave in Lead III. He died February 27, 1943. Duration of life, one year, one month and fifteen days.

Case XIII. Mr. V. U., colored male, aged fifty. On April 21, 1942, he was complaining of dyspnea and choking-up spells. For more than a year he had had smothering-out spells in his chest. He got relief by drinking hot whiskey and at times by strokes on his chest with his hands. The pain was brought on by effort. The pain in his chest radiated to the left shoulder and to his wrist. He complained of hot flushes. He had been short of breath for six months and had had cramps in his legs. Auscultation of the heart revealed a faint systolic murmur at the apex and the arterial blood pressure was 150/80 millimeters of mercury. His vital capacity was 2400 cc. An electrocardiogram taken April 23, 1942, revealed the following: there was a convex S-T segment and an inverted T-wave in Leads I and IV-F. The S-T segment was elevated in Lead II and iso-electric in Lead III. There was an upright T-wave in Lead III. There was a QS wave in Lead IV-F. The patient has lived for the duration of four years, three months and nineteen days.

Case XIV. Dr. J. C. C., colored male, aged fifty-six. On January 25, 1943, he complained of extreme weakness in general, but particularly in his legs. Ten days before he had what he called an acute attack of indigestion. The pain was in the epigastric region, associated with dyspnea. Auscultation of the heart revealed a systolic murmur at the apex and base with A_2 accentuated. His arterial blood pressure was 140/80 millimeters of mercury. His vital capacity was 1700 cc. An electrocardiogram taken January 25, 1943, revealed the following: there was a convex S-T segment in Leads I, II, and III, followed by an inverted T-wave. In Lead IV-F the S-T segment was elevated. The patient has lived for the duration of three years, six months and twenty-five days.

Case XV. Mr. J. T., colored male, aged sixty-five. On May 5, 1943, he suffered a severe misery at midsternum, at night, with shortness of breath. A doctor was called, who gave him a "shot" and told him to get in touch with his family doctor the next day. In the past he had had asthma and dizzy spells for several years. On physical examination, his temperature was 99 F., his pulse rate was 100 beats per minute. He had many defective teeth. Auscultation of his heart revealed a presystolic murmur at the apex and a systolic murmur at the base with A_2 accentuated. There was an expiratory wheeze throughout his chest. His arterial blood pressure was 180/110 millimeters of mercury. Laboratory findings revealed the urine showed a 4 plus albumin. Electrocardiograms, taken May 5, 1943, and October 9, 1945, revealed the following: in the first there was a convex S-T segment in Leads I, II, and IV-F, with inverted T-waves; in Lead III, there was an upright T_3. In the second there were the following changes: the T-wave was inverted in Lead I and upright T-waves were in Leads II, III, and IV-F. The patient has lived for the duration of three years, three months and fifteen days.

Case XVI. Mrs. B. B., colored female, aged fifty-five. On June 11, 1943, while she was reading in bed, there was a sudden onset of a severe squeezing in her chest which cut off her breath. She had the windows opened so she could get air. She was given some medicine for gas; not being relieved, she jumped out of bed and ran out in the street, screaming. She was given a "shot" by a doctor,

who informed her to get in touch with her family doctor the next day. She vomited. She had had hight blood pressure for more than ten years. She had repeated attacks of dizziness and shortness of breath. She had a hysterosalpingo-oopherectomy and an appendectomy in March, 1939. Auscultation of the heart revealed a systolic murmur at the base and apex. The arterial blood pressure was 220/140 millimeters of mercury. In October, 1945, she fell in a newspaper office. An electrocardiogram taken June 12, 1943, revealed a cove plane T-wave in Leads I, II and IV-F. There was an iso-electric S-T segment and an upright T-wave in Lead III. She died October 28, 1945. Duration of life, two years, five months and seventeen days.

Case XVII. A. H., colored male, aged thirty-six. On April 24, 1945, he complained of a pain in his epigastric region, and a headache, which he had had for more than two months, also a cough. Physical examination revealed the temperature 99.4 F. and his pulse rate was 100 beats per minute. His arterial blood pressure was 250/80 millimeters of mercury. He had large turbinates and tonsils. His heart had a systolic murmur at the apex and base, with A_2 accentuated. He had a slight tenderness in the epigastric region and ventral hernia. His urine showed a 4 plus albumin. The patient died March 16, 1946. An electrocardiogram taken May 8, 1945, revealed that the S-T segment was depressed in Lead I, and in Leads II and III there was a convex S-T segment within version of the T-wave, with a W-type of QRS complex in Lead III. There were normal complexes in Lead IV-F. Duration of life, ten months and twenty-two days.

Case XVIII. Dr. B. P., colored male, aged forty-six. On February 17, 1944, he complained of feeling weak and of having a rapid heart rate. Three months before, while sitting down, he had a sudden onset of a severe pain at the midsternum, with shortness of breath and sweating. He took soda, after which he vomited. His family physician came and gave medication and started to leave but the patient insisted that the physician remain until he had relief. He vomited bile, and had a cough and rales in his lung bases, for which he was given sulphathiazole for relief. Auscultation of the heart revealed a soft systolic murmur at the apex. His arterial blood pressure was 130/90 millimeters of mercury. His temperature was 99 F. and his pulse rate was 100 beats per minute. Electrocardiogram taken February 27, 1944, revealed that there were progressive changes, with the T-waves coming upright in Leads I and II and inverted in Lead III. There was a Q_2 and Q_3 and a QS wave in Lead IV-F. Another electrocardiogram taken March 29, 1944, revealed the following changes: the T-waves were more definite in Leads I and II and the T-waves were less negative in Lead III. The patient has lived for the duration of two years, six months and three days.

Case XIX. Mr. C. M., colored male, aged fifty. On January 25, 1945, he complained of pain in the midsternum which radiated down the left shoulder to his elbow, associated with tightness in his chest. He had had shortness of breath intermittently, for two years. Auscultation of the heart revealed a soft systolic murmur at the apex. His arterial blood pressure was 120/60 millimeters of mercury. An electrocardiogram taken January 25, 1945, revealed that the S-T segment was elevated in Leads II and III. There was a Q_2 and Q_3. Another electrocardiogram taken February 14, 1945, revealed the following changes: there was a positive T_1 and the T-waves were less negative in Leads II and III, also the QS_3 was less negative. The T_4 was taller and more acute. The patient has lived for the duration of one year, six months and twenty-five days.

Case XX. Mrs. L. B., colored female, aged sixty. On June 15, 1944, she complained of shortness of breath, dizziness, weakness, and swelling of her legs. This had been going on for more than three years. The weakness had gradually become worse and she was confined to bed. The physical examination revealed rales in the lung bases. The heart had a systolic murmur at the apex and A_2 was accentuated. Her arterial blood pressure was 200/100 millimeters of mercury. Her urine showed a slight trace of albumin and her Wassermann was positive. An electrocardiogram taken July 23, 1944, revealed an iso-electric S-T segment in Leads II and III. There was an upright T-wave and an S-wave in Leads I and II. There was a convex S-T segment within version of the T-wave in Lead IV-F. The rhythm was irregular and the QRS interval measured .20 of a second. The patient has lived for the duration of two years and twenty-seven days.

The electrocardiographic diagnosis of acute coronary thrombosis was of great value in making the diagnosis certain. In classifying the two types of acute coronary thrombosis we have: (1) the anterior type, which is the T_1^5 type, frequently associated with the infarction of the anterior surface and of the apex of the left ventricle, that is, in the distribution of the anterior descending branch of the left coronary artery; and (2) the T_3 type, with the infarction of the posterior and basal part of the left ventricle, that is, in the distribution of the posterior circumflex branches of both right and left coronary arteries. In this series of twenty cases sixteen were of the anterior type, in which the characteristics of infarction in the three conventional leads were in accord with those in the precordial leads. There were four cases of posterior infarction, or the T_3 type, in two of which, cases

5. (a) Parkson, J. and Bedford, D. E.: Successive Changes in the Electrocardiogram After Cardiac Infarction (Coronary Thrombosis), *Heart J.* 14: 195, 1927-29.
(b) Barnes, A. R., and Whitten, M. B.: Study of the RT Interval In Myocardial Infarction: *Am. Heart J.* 5: 142, 1929-30.

TABLE I

		Sex	Age	List of Dead at End Of— Yrs.	Mo.	Days	
ANTERIOR		F	65		6		
	(F-2)	F	50		10	10	1st YEAR 25%
	(M-2)	M	63		9	1	
		M	50		2	3	
POSTERIOR	(M-1)	M	36		10	22	
ANTERIOR	(M-1)	M	57	1	1	15	2nd YEAR 5%
	(F-2)	F	44	2	3	2	3rd YEAR 10%
		F	55	2	4	17	
	(F-2)	F	50	3	8	11	4th YEAR 10%
		F	57	3	2	3	
	(F-1)	F	55	4	0	7	5th YEAR 5%

Male dead—4 (20%). Female dead—7 (35%).

TABLE II

SYNOPSIS

B.P.	Living or Dead	Percent of Deaths	Duration of Life ETIOLOGY	Year	Mo.	Day	Age	Sex
ANTERIOR		60%						
No. of cases—16								
1. 160/80	D		Hypertension		10	10	53	F
3. 220/190	D		Hypertension	3	8	11	50	F
4. 260/160	D		Hypertension		9	1	63	M
5. 200/90	D		Hypertension	4	0	7	52	F
6. 130/60	D		Hypertension Syphilis		2	3	50	M
7. 140/80	D		Hypertension	3	2	3	57	F
8. 210/110	D		Hypertension		6		65	F
9. 200/100	L		Hypertension Syphilis	6	10	10	49	M
10. 150/90	L		Hypertension Syphilis	5	6	10	53	M
11. 240/120	D		Hypertension Syphilis	2	3	2	44	F
12. 160/90	D		Hypertension Syphilis	1	1	15	57	M
13. 150/80	L		Hypertension	4	3	29	50	M
14. 140/80	L		Hypertension	3	6	25	56	M
15. 180/110	L		Hypertension	3	3	15	65	M
16. 220/140	D		Hypertension	2	4	17	55	F
20. 200/100	L		Hypertension Syphilis	2	0	27	60	F
POSTERIOR		25%						
No. of cases—4								
2. 140/80	L		Hypertension	8	7		36	F
17. 250/80	D		Hypertension		10	22	36	M
18. 130/90	L		Hypertension	2	6	3	46	M
19. 120/60	L		Hypertension	1	6	25	50	M

XVII and XIX, the three conventional leads were characteristic of infarction, but the chest lead was atypical. In cases IV, V, VII, IX, XII, XIV, XVII, and XX, in which there were questions as to the diagnosis, the electrocardiogram made the diagnosis certain. In case number II, in which there was a slight change in the three conventional leads, the fourth lead revealed the answer.

The history of most of these cases with sudden attacks of retrosternal pain of various names, as misery, squeezing, choking, smothering, crushing, hurting, weakness, indigestion, some with radiation and dyspnea, sweating, fear of death, and vomiting, may strongly suggest the diagnosis of acute coronary occlusion; also, the fall in blood pressure, gallop rhythm, or cardiac irregularity. As to sex, it occurs more frequently in men than in women; as to age, in the fourth, fifth, and sixth decades of life. Hypertension may be a factor, as well as the family history.

The electrocardiograph in the prognosis of acute coronary thrombosis is of value in this respect, in revealing the two types of coronary infarction: the anterior type in which there were more cases, as well as more deaths; the posterior type is less common, with fewer deaths.

In this series of twenty cases, eleven were men and nine were women. Of this number, four men and seven women are dead, and the remaining seven men (35 per cent), and two women (10 per cent), are living. The deaths are listed in Table I:

The abnormalities in the electrocardiograms in this series, whether slight or of great changes, were of little prognostic value. There were no clinical signs nor symptoms that made it possible to predict the immediate or future outcome of the patient. The prognosis, therefore, should always be hopeful but guarded.

In conclusion, the electrocardiograph is of definite value in the diagnosis of acute coronary thrombosis, as indicated in these twenty cases. The electrocardiograph was of prognostic value as shown in the twenty cases listed. The immediate and ultimate prognosis of coronary occlusion is extremely difficult to predict. The physician should always be hopeful, but guarded, in rendering a prognosis.

This report accounts for, as previously mentioned, twenty cases, 80 per cent of whom were anterior and 20 per cent posterior occlusions. It will be seen further that 45 per cent were females and 55 per cent males. The mortality is accounted as 45 per cent living and 55 per cent dead. Of the living, 35 per cent are men and 10 per cent are women.

STILL DIFFICULT TO APPRAISE VALUE OF BCG VACCINE FOR TB

The results of the use of BCG (Bacille Calmette-Guérin) vaccine as an immunizing agent in tuberculosis are influenced by so many factors, says an editorial in the November ninth issue of *The Journal of the American Medical Association*, that "accurate evaluation is still difficult."

"All reports agree that the vaccine properly prepared and used is harmless, as cases of tuberculosis caused by BCG vaccine have not been reported thus far."

THE JOURNAL editorial, entitled, "BCG Immunization," follows by only a few days the U. S. Public Health Service's announcement from Washington that the vaccine, which has been available in Europe since about 1920, will be given widespread studies in this country.

BCG is named for two French scientists, Calmette and Guérin, who developed it at the Pasteur Institute in Paris.

The decision to make a wide-scale study in the United States of the effect of the vaccine in man was reached after a conference in Washington of tuberculosis experts from China, Denmark and the United States. It has already been used on test groups in Chicago and New York and on western Indian reservations, as well as in Europe and South America.

THE JOURNAL'S editorial says in part:

"Holm of Denmark states that since 1940 vaccination with the bacillus of Calmette-Guérin has been adopted in that country as an essential weapon in the fight against tuberculosis. A large part of the young people of Denmark are tuberculin negative. Since it is known that tuberculin-negative persons acquire tuberculosis much more readily when exposed, BCG vaccination is believed to be a valuable adjunct in the control of tuberculosis.

"The Tuberculosis Dispensary of Copenhagen reports that morbidity and mortality from tuberculosis among the children in a tuberculous environment have been reduced following vaccination to almost zero. Previously mortality among children exposed to tuberculosis in their homes was high, but in recent years children thus exposed have not died of tuberculosis, and children who become ill have a much milder form of tuberculosis than previously observed. Holm concludes that BCG vaccination gives considerable, although not absolute, protection.

"The allergy produced by the vaccination lasts more than three or four years. In the health department of Bergen, Norway, among 4,400 persons vaccinated who were observed up to three years only one developed ulcerative pulmonary tuberculosis and eleven developed tuberculosis of the hilar lymph nodes. The National Society Against Tuberculosis in Norway favored mass vaccination in 1945.

"Levine and Sackett, reporting the results of BCG immunization in New York City, assume a more conservative attitude. Although most reports have been optimistic, they feel that the vast majority of these studies have been inadequately controlled.

"The authors point to a number of factors which could effect the comparative results, such as parental cooperation, economic conditions, racial distribution, exposure, and lost cases. . . .

"The efficacy of BCG vaccination must be judged by its ability to reduce the tuberculosis mortality of children vaccinated in their homes in the midst of tuberculous environment. The authors conclude that as a public health measure the routine vaccination with BCG of children from tuberculous homes is less advantageous than removal of the tuberculous subject from the home."

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

THE NEW DEAL IN MEDICINE

FOR some time the medical press has been concerned with the problems of hospital staff organization and the role of the general practitioner in the picture. The common tenor of these expressions has to do with the virtues and vices of specialty boards and the attitude of the American College of Surgeons in imposing a set pattern of regulations for organization of hospital staffs under penalty of forfeiture of approval and consequent loss of interns.

No one seems to find any particular fault with the objectives of specialty boards, which are primarily directed toward the elevation of specialty practice and the expectant welfare of the patient. Many, however, are vocal concerning the by-products, offshoots, and applications of certification by a specialty board. In most instances this is directed toward the growing tendency of hospitals to insist on board certification before acceptance to staff appointment. Thus we find the general practitioner sitting in the hot spot between the anode of specialization and the cathode of regimentation.

Attention has been called recently to five principal reasons given by men, applying for medical licensure, for their decision to specialize. Application of knowledge already acquired in specialized work, more remunerative practice, less arduous type of practice, attitude of hospitals in staff appointments, and prestige of the specialist were the condensed reasons given; not one, apparently, having to do with the elevation of the standards of a specialty or the expectant welfare of the patient, but all having to do with purely personal advancement. Only 10 per cent of the number expressed the desire to go into general practice.

One might well question, therefore, whether the creation of the specialty boards has not produced a device that will ultimately destroy the general practice of medicine unless measures are found to block the tide of impositions, regulations, and unfair practices stemming from the assumed superiority which certification in a specialty appears to be producing.

Medicine finds itself in a centrifuge of disintegration. The component whole is being fractionated into specialties, and the general practitioner is being settled out as waste material. Such a condition cannot, and undoubtedly will not, be allowed to persist. Organization, aggressive representa-

tion, adequate and equal recognition, competent and fair administration, and impartial use of physical facilities for the care of the sick must be the aims of any group of practitioners who would consolidate to balance the wheel and correct growing injustices in medical practice. Such an organization has already been formed. It is known as the American College of Physicians and Surgeons. Its general purposes deserve the consideration of every general practitioner interested in his own economic welfare. Its progress will be watched with much interest.

Only the most nearsighted and prejudiced of individuals could cavil at the activities of the American College of Surgeons, over the years, in its attempts to elevate the standards of hospitals and hospital practice. In most instances its recommendations have been received in a cooperative spirit and certainly great progress has resulted under the urge of moderate suggestions and helpful programs and conferences.

Now, however, the cloak of interested counselor appears to have been cast aside in favor of the whiplash of regimentation and set-pattern regulation, and the mandate of conformation under penalty of disapproval for intern and resident training. Reorganization must be undertaken and departmentalization becomes a necessity. A master plan is offered, the salient points of which must be incorporated in the new organization. Attendance at staff meetings becomes mandatory. A select committee will scan all records of private patients and grade each member according to the record. Limitations will be arbitrarily placed upon the activity of various members. All rules and regulations and by-laws must be accepted by each staff member and he must sign his acceptance of conformation to these edicts. This is a nation-wide movement.

Well, upon such planning was the New Deal built. Centralization of government, rules, regulations, edicts, directives—all with the basic idea of controlled economy and limited enterprise. Are we to anticipate the New Deal in Medicine?

We may be wrong in clinging to the old-fashioned idea that every member of the medical profession, properly licensed to practice, with adequate training and preparation, is professionally honest until shown to be dishonest, and is entitled to all the rights, advantages, and liabilities of his calling. We further subscribe to the expressed premise "that no special interest group shall have the right to control or hamper the practice of any duly licensed physician or surgeon according to his judgment or to dictate or to influence the treatment or the disposal of his patients or to deny him or his patients access upon an equal basis to the physical facilities necessary or convenient to his practice and the treatment of his patients."

We feel, in addition, that attempts to regulate and dictate the plan of operation of hospitals, and their manner of organization and administration under compulsion and penalty, is an unwarranted intrusion upon the rights of hospitals and staff members in the conduct of their professional activities. Those hospitals which today are intern-staffed are, of necessity, going to maintain their own high standards of practice in order to offer a desirable appointment. Those which are not so staffed will, in the majority of instances, be forced to maintain high standards by reason of competition or public opinion. No master plan, no centralized dictation of policy, no infringement upon honest methods of practice, no assumed control "of economic, social or scientific status," will serve to elevate the standards of the practice of medicine or the welfare of patients. They will breed a spirit of rebellion, the occasion for which is not good for Medicine.

If there is any prestige connected with the medical profession it exists, primarily, because of the individual doctor and his relationship with his patients. It has been fostered and enhanced, secondarily, by his manner of cooperation and industry in working with his colleagues in groups and organizations. It has grown and blossomed because of glorious accomplishments by individuals and cooperating groups. Initiative, honesty, and ability have fertilized the respect of the community for the doctor. It is not probable that any of the prestige of the medical profession came into being because of the existence of any great organization. In fact, there is a sizeable percentage of the population that has little regard for *organized* medicine.

Aside from that, the doctor has done a pretty fair job of elevating the standards of practice in the community in which he moves, and has been quite successful in keeping the welfare of his patients in mind. We don't believe he will appreciate remote control.

GRATEFUL PATIENTS

CAME the war, with the consequent shortage of physicians, due to thousands of them having enlisted in the Medical Corps of the Armed Services. Those remaining at home to carry on civilian practice found themselves in a dilemma. The answering of calls was in many instances delayed and, on occasion, night calls were of no little concern to both doctor and patient.

Postwar conditions were, of course, improved, once the service doctors got back on the job and had re-established themselves. But there have been many complaints voiced about the answering of calls by physicians here and there, not only in Indiana but elsewhere over the country.

There are several explanations for this, one of the most important being that the older group of physicians, those who remained at home during the war and in too many instances did overtime and double time duty, have reached the age where they no longer can carry the load they used to bear. Five years of strenuous activity have taken their

toll and it is little wonder that these older men feel that they are entitled to a lessened activity. Many have eliminated obstetrics, leaving that work to the younger men; many have tabooed night calls, save in dire emergencies, asking that the younger men take over these calls.

Naturally, there is some complaint about this and, just as naturally, many of these complaints are ill-founded. The medical profession continues to offer medical care to all, on the other hand they ask some indulgence on the part of Mr. John Q. Public. We still have a large group of practitioners in Indiana who are well past the "retirement age" of sixty-five, but who are willing to carry on for a few more years, provided the task is not too heavy. Occasionally, some kind soul expresses a bit of appreciation for all these things, such as a Vox Pop letter in a recent number of *The Indianapolis Star*.

We trust that every one of our members will take the time to read this and to pin it well up front in their memory—it is a letter that should be read by all physicians, as well as by all laymen:

"DOCTORS ARE REAL MEN

"To the Editor of The Indianapolis Star:

"When I first moved my family here we didn't know anybody, and we lived in a run-down rooming house. That was where I got my first opinion about Indianapolis doctors. We ran into a streak of illnesses and bad breaks, enough to break a camel's back. There was not one doctor that we asked for help who refused. We had to wait our turn, who didn't? particularly during the war. There was one, a surgeon, who refused to send us a bill for an operation that saved one of our boys the use of his limb. 'I want to pay it!' I told him. 'Forget it,' he said, 'you've had more than your share of trouble.' We owed five doctors. When they were paid, in small weekly payments over a two-year period, the surgeon was mailed payments, too. But we hadn't half paid what we owed them when a receipt came marked, 'Paid in full. And thanks!' He was a prince.

"So doctors are 'gruff, arrogant and money-minded,' are they? Out of those five doctors there wasn't one that I'd call a good businessman. If I managed my affairs that way we'd still be in that run-down rooming house."

TOO MUCH OF A GOOD THING

THE editorial, "Too Much of a Good Thing," was noted in the *Terre Haute Star*, of April 25, 1947, by a former president of our association. In sending it to us he remarked "Editor Benham has put his fingers upon the sore spot in our relations to the public. Either we must return the family doctor to the people, or they will seek relief through some kind of state medicine. The problem is as simple as that. During fifteen years of heated discussion of the question, we have found no plan that remotely suggests a solution."

"TOO MUCH OF A GOOD THING

"A speaker at a conference on medical education said 90 per cent of medical students today seek to join clinics in order to become specialists. Such a figure suggests medicine may be getting too much of a good thing and that the present trend, while a boon to the science of healing, may turn out to be a little hard on the patient.

"Specialization is wonderful. It has brought mankind far along the road from the medical Dark Ages. It has conquered many killing diseases, and it will conquer many more. It has saved countless lives.

"It is small wonder, then, that most doctors want to specialize. A professional lifetime is not too long to spend on many single branches of medicine or surgery. This concentration leads to highly developed skills and knowledge.

"As skills increase so do the opportunities for a lucrative practice. Specialists tend to gravitate to the cities, where there are ample facilities for their work and where patients are likely to be more prosperous as well as more numerous. All this is fine if it doesn't go too far. But the present trend threatens serious neglect of one important field in medicine.

"That is the field of general practice. Some effects of over-specialization are already apparent. Many rural communities are experiencing a shortage, both in quantity and quality, of medical assistance. The young men specialize and go to the city. The rural community's health becomes the responsibility of a few old-timers.

"In cities, too, it is often difficult to find a general practitioner. There are specialists galore. But, outside of crowded clinics, it is sometimes a real feat to get a general examination or treatment for a minor ailment.

"The problem extends beyond the tangible realm of statistics. For there is a real need, in this troubled world of apprehensive people, for a modern counterpart of the old-fashioned family doctor.

"The general practitioner of grandfather's day may have been ill-equipped in science. His black bag may have held only primitive weapons against disease. But, if he was a good doctor, he had something that is lacking in many of his learned successors today.

"Too many specialists today offset the help they give by an abrupt, impersonal manner. They become too busy or too absorbed to remember that the patient is a complex human being as well as an interesting or routine case. They are inclined to forget that an illness is important to its sufferer, who benefits from a little warmth on the doctor's part.

"We don't have the prescription that will save the family doctor from threatened extinction. Group practice, maybe. But we are sure there is a real need today for the kind of doctor who used to be able to bring an anxious household a feeling of reassurance the moment he came in the door."

THE SPRING CROP OF RACKETEERS

WE do not know why these folk choose springtime to sally forth, seeking the gullible, but it is an established fact that this is the season when these crooks are most active, maybe because through the winter months they have little to do, so spend their days in thinking up new schemes, getting them all polished up, and practicing their glib-tongued "salesmanship."

Another reason may be that with the first signs of the coming of spring most everyone has the urge to plant something, clean up and re-seed the lawn, set out some new shrubbery and trees, and that sort of thing. They study the seed catalogue, envisioning their home surroundings a veritable bower, so that, mentally, they are all set for the coming of these fakers.

About the first to come along are the "black dirt" salesmen; they always claim to have just the right amount of humus in their product and, at the least sign of interest, they will spread a bushel, right before your eyes, calling attention to how much grass one bushel will cover. They set the price at so much per bushel and get to work, the householder getting back to some uncompleted task inside the home. The Indianapolis Better Business Bureau reports instances in which the charge for this "service" amounted to fifty dollars.

Then, according to the Bureau, there are painters and roofers to contend with, also termite exterminators. These three can, and do, put on a swell job of gyp, due to the fact that the average householder knows little about such things. The paint begins to peel off soon after the bill has been paid, the roof shows leaks where none had been noted before, while the little termite goes on about his business with greater gusto, probably finding the preparation used as an exterminator a choice bit of breakfast food.

There is another group that should not be given a hearing—the "Tree Surgeons." Yes, there are legitimate firms doing this work, their employees being well trained before setting out on a job: Davey, Bartlett, Swain Nelson, all reliable firms and who know how to do things, as well as when to do them. Of course, there are dozens and dozens of other reliable firms, but these three come to our mind.

But what of some of the house-to-house canvassers? Most of them know nothing about tree trimming, other than to cut off a sizeable pile of branches, not forgetting to make exorbitant charges for this "service." Many trees and shrubs are utterly ruined by these shysters and it is a matter of many years ere the damage can be repaired.

"Only God can make a tree," and only a competent, well-trained tree surgeon can assist in the process.

We might go on, mentioning many other rackets that show up with this season, but the ones above enumerated will suffice to make us be on the alert and save our trees, as well as our money.

Most of us have a bit of the farmer within us; we like to see things grow, we like to study this growth and, mayhap, do a bit of experimenting, ourselves. But when we need real help, we need *expert* help; we want to be certain that the man operating on our growing things knows what he is doing. He will tell you how to feed your trees, come next October; he will tell you when to use the dormant spray and, later on, the arsenic treatment. Most of us know how to grow things—all of us need a lot of assistance in the growing thereof.

Editorial Notes

The Indiana Neuropsychiatric Association is arranging for a dozen or so of its members to serve as consultants in the state hospitals, thus relieving the load on staffs already undermanned. Veterans Administration Hospitals also are to take advantage of this proffer. It was recently stated by Dr. Norman Beatty that in one institution each staff psychiatrist had a "case load" of more than 500 patients; obviously, this does not make for efficient treatment, and the offer of the state association will materially relieve this situation.

The American College of Radiology gives us a new word—aero-sinusitis. Recent observations on the part of flight surgeons show that rather large numbers of airmen, flying at altitudes of 18,000 feet or more, are susceptible to this trouble. It is characterized by a sudden, sharp pain over either eye and is said to be due to the difference in the air pressure within the sinuses and that of the surrounding atmosphere. The acute, sudden pain is likened to that of a bee sting. The prognosis in these cases usually is good.

The New York Times, of April 15, comments on the smallpox "scare" experienced in that city since April 4, when the first of eight cases was reported. Two of the patients died from the disease. Health Commissioner Weinstein at once put into operation a plan for a city-wide vaccination program. *The Times* comments on the fact that at one time the wating line of those seeking vaccination at Fordham Hospital exceeded 4,000, and the same was true at other emergency stations. Each case was traced by the health department, and it was found they all stemmed from the one source, the first case reported. The American people are a "peculiar" people; they long since have known that smallpox, while no longer of the epidemic category, still exists and sporadic cases show up here and there over the country. By the same sign, they are fully aware that vaccination affords protection to a degree of practically 100 per cent. They also know that, properly done, vaccination is a harmless measure—yet they go complacently along until the disease rears its ugly head—then want vaccination, right now.

Most any day now you will be receiving a note from Uncle Sam to the effect that your annual narcotic registration, with the tax of one dollar, will be due. We would suggest that this little matter be attended to immediately upon receipt of the statement, thus forestalling neglecting to look after it before July 1. Your office assistant easily can take the inventory and prepare the two forms, all ready for your signature and the enclosing of the one dollar.

During the war, the Army Medical Library through its photoduplication services supplied millions of pages of microfilmed medical articles to the armed services and other research agencies. The principal of immediate aid direct to the user, wherever he might be, introduced a new technique to assist medical research. This service is now generally available for civilian physicians, institutions and research workers on a cost basis. This means direct access to the library's enormous resources of medical literature. A fee of fifty cents is charged for filming any periodical article in a single volume, regardless of length. Microfilming from monographs is furnished at fifty cents for fifty pages or fraction thereof. Photostats are also available at a charge of fifty cents per ten pages or fraction thereof. Material filmed is not for reproduction without permission of the copyright owner. For convenience and to keep bookkeeping costs down, a coupon system has been established. Users may buy any quantity of photoduplication coupons at fifty cents each. Order blanks are available upon request. Checks should be made payable to the Treasurer of the United States, and sent to the Army Medical Library, 7th St. & Independence Ave., S. W., Washington, 25, D. C.

Now we have something really new, a machine that will record "brain waves." This instrument recently has been installed in Methodist Hospital, Indianapolis, under the direction of Dr. John Greist. The waves are recorded somewhat in the same manner as by using the electrocardiograph. Just in what manner these findings will be of most benefit to our brain surgeons still is somewhat problematical, but it is announced that the device will in nowise help the operator to know what the patient is thinking about. The study of convulsive disorders will be greatly enhanced by use of the machine and it is hoped that further research will offer many other valuable uses for it.

Are you all set for the new Indiana cigarette tax that will be coming along on July 1? This amounts to the small sum of three cents per package, yet the gross "take" from this source, annually, is estimated to be something like thirty-eight million dollars, according to a recent newspaper report. This money is earmarked for definite purposes, much of it to help take care of the raise in wages for Hoosier schoolteachers. Technically, the law provides that this income shall be used for "general education, general and mental health programs, and for other general welfare programs as the governor may direct." Somehow or other, most physicians use cigarettes and, according to advertising plugs still used by one manufacturer, some 20,000 of them were foolish enough to state that this brand was "kinder to the throat" than any other. Of course, for this little testimonial, each one received a carton, "free gratis for nothin'!"

Request for Scientific Exhibits

The Committee on Scientific Exhibit for the 1947 annual meeting of the Indiana State Medical Association is making plans for an interesting and instructive display at French Lick. The foyer of the convention hall and the rear of the convention hall have been reserved for the exhibits. Anyone having something of interest to display is requested to contact Dr. J. L. Arbogast, Indiana University Medical Center, Indianapolis 7, Indiana, the committee chairman.

President's Page

MOTHER-IN-LAW

BY exercise of considerable restraint over some months past, I have refrained from commenting upon the present situation regarding governmental intrusion into medical practice. However, the rising sap having pushed out the blossoms and leaves, I also am about to burst forth.

Should we now relax into morpheus-like complacency relative to political medicine? This is not the opinion of those who look even but slightly beneath the surface. I quote one of our able ex-presidents, Dr. N. K. Forster, Hammond, who, but a few weeks following last fall's election, wrote to me as follows: "The Republican victory means only a short breathing spell—actually the one minute rest between rounds—because surer than life itself, the politicians of *any* party are going to seize the opportunity to improve their own position in the eyes of the public by advocating some form of controlled medical practice and medical care. We are the 'soft under-belly' through which the collectivists and the dominant political party will *undoubtedly* seek to increase and enhance their power, no matter what you call them." (Italics his.)

With the above I agree one hundred per cent, and every thought could be underscored. Why? Because subsequent events, events which as yet have not been headlined in the daily press, lead to that inevitable conclusion.

Accordingly, inspired by the syndicated columns of Dorothy Dix and Doris Blake in their almost daily references to the difficulties encountered in family relationships when Mother-in-law is a permanent guest of the family, I have attempted to draw a parallel of what could happen when government, in like manner, sits at our table in charge of our professional lives.

PARABLE OF MOTHER-IN-LAW

Mother-in-law is standing on our doorstep, her finger pressing the button, awaiting the opening door. Superficially newly attired, she attempts an imposing and inviting picture; too, by the looks of her baggage and trappings, me-thinks she is prepared for permanent stay in our household. Perhaps!

Senators in Washington, *from both sides of the aisle*, together have given Mother-in-law her annual bath, and she now piously presents herself with presidential blessing and a piano accompaniment, an obligato, entitled: We don't know where we're going, but we're on our way.

Mother-in-law not only has been recently bathed, she also is freshly powder-scented and highly perfumed; however, you may scrub her and brush her as well as you will, her fulsome b.o. remains with her still. In fact, Mother-in-law smells!

We notice, too, on closer inspection, that her jewelry is quite flashing, her dress a bit loud, and her skirts amply wide. We don't quite know what she's concealing beneath those skirts—she may be a pistol-packing mamma. Indeed, she may be toting dynamite! Certainly a few Ethiopians are bulging her pants pockets. We cannot see their black faces, but we just know that they are there.

Yes, Mother-in-law may be contemplating wearing the "pants" in our household. I'm very suspicious. She surely will have a grasping hand in our financial pants pocket. To what extent? We don't quite know. Again, I'm very suspicious.

Mother-in-law is a bit "tight," financially. Prior to now, she would not permit a county medical society, as such, to adopt a fee schedule; that would be illegally in restraint of trade. But she now demands identically written contracts at state and national levels, and she even asks from every individual physician an iron-clad signed agreement. She's the sort o' gal who plays bridge upon the principle that a sly peek at opponents' cards is better than two finesses. At least she peeks ad lib into our income tax returns. Further, Mother-in-law not only demands the right to audit and police our accounts, she also wishes to regulate our services.

Now Mother-in-law likes the best of everything and, of course, is entitled to it. But, is she willing to pay for it in proportion? I'm not so sure. Previous experience does not encourage the prospect. I'm certain, though, that Mother-in-law does not want the grocery boy to administer an anesthetic, the tinsmith to take out an appendix, the plumber to do urology, the carpenter to splint fractures, the excavation contractor to remove brain tumors, or the herb-doctor to deliver babies and to prescribe medicines. Yet, just what does Mother-in-law want? We don't exactly know. Perhaps, neither does she! So, it may just happen that we'd better be a bit careful in our relationships and signed contracts with Mother-in-law.

MORAL

With our household properly *organized*, we could and should say to Mother-in-law: American Medicine has the savey and the know-how to practice medicine; we gladly and willingly offer to you and to your wards our best services; these are the conditions; this is the price.

Sincerely,

Floyd L. Romberger

DR. WYNN HONORED BY A.M.A.

Originator of Scientific Exhibit

THURMAN, B. RICE, M.D.

INDIANAPOLIS

PHYSICIANS visiting the American Medical Association meeting at Atlantic City will wish to look up Booth 301 where Dr. Frank B. Wynn is being honored as the originator of the scientific exhibit idea. In the nineties Doctor Wynn was a very energetic young physician who believed tremendously in the value of pathology, bacteriology, and scientific approach toward diagnosis and treatment. He had prepared an exhibit of bacteriological and pathological specimens which was shown at the LaFayette meeting of the Indiana State Medical Association, in 1898. The exhibit had elicited much interest and the opinion was expressed that it should be continued and used more widely.

When arrangements were being made for the 1899 meeting of the A.M.A., which was to be held at Columbus, Ohio, someone made the suggestion that the state medical association allow Doctor Wynn three hundred dollars for expenses to take the exhibit to Columbus. No provision was made by the American Medical Association for it, so it was necessary to rent a storeroom for this purpose. Shelves were built along the sides and a table with other shelves was set up in the center. Something over seven hundred specimens were demonstrated. A great deal of interest was shown, and as a result it was decided that such an exhibit should be made each year, but under the auspices of the American Medical Association rather than a state organization. A committee was appointed to get up such an annual exhibit and Doctor Wynn was made chairman of it. He continued to be chairman for a number of years.

Other physicians honored are Dr. William Niles Wishard, Dr. A. W. Brayton, Dr. Frederick Potter, and Dr. J. N. Hurty, all of whom helped him in some way to get the exhibit together, and who backed him with their influence as he was setting out on so new and ambitious an undertaking.

Such is the humble origin of the great exhibit which is now the most striking feature of the annual meeting. When Dr. T. C. Hull, Director of the Scientific Exhibit of the A.M.A., came to be aware of the point of origin of the exhibit he asked that Doctor Wynn be honored and gave appropriate space for this purpose. It will be a very nice honor for him and also recognition for the Indiana State Medical Association. The friends and students of Doctor Wynn remember him as a very fine gentleman, capable, kindly, and sincere. He was highly qualified to teach the courses in medicine, and as a foundation for that career felt that his training in bacteriology and pathology (both very young subjects in that time) had done a great deal toward preparing him for his career as a physician.

Look for Booth 301. It will be to the right of one of the main entrances to the Exhibit Hall. The exhibit is prepared and will be in the charge of the author.

VENOUS THROMBOSIS INCREASING

Two Baltimore physicians point out that venous thrombosis is on the increase because more operations are performed today.

Writing in the April 26 issue of *The Journal of the American Medical Association*, the physicians—Thomas B. Aycock and James W. Hendrick, from the Department of Surgery, University of Maryland School of Medicine and College of Physicians and Surgeons—suggest treatment for the two types of venous thrombosis, phlebothrombosis and thrombophlebitis.

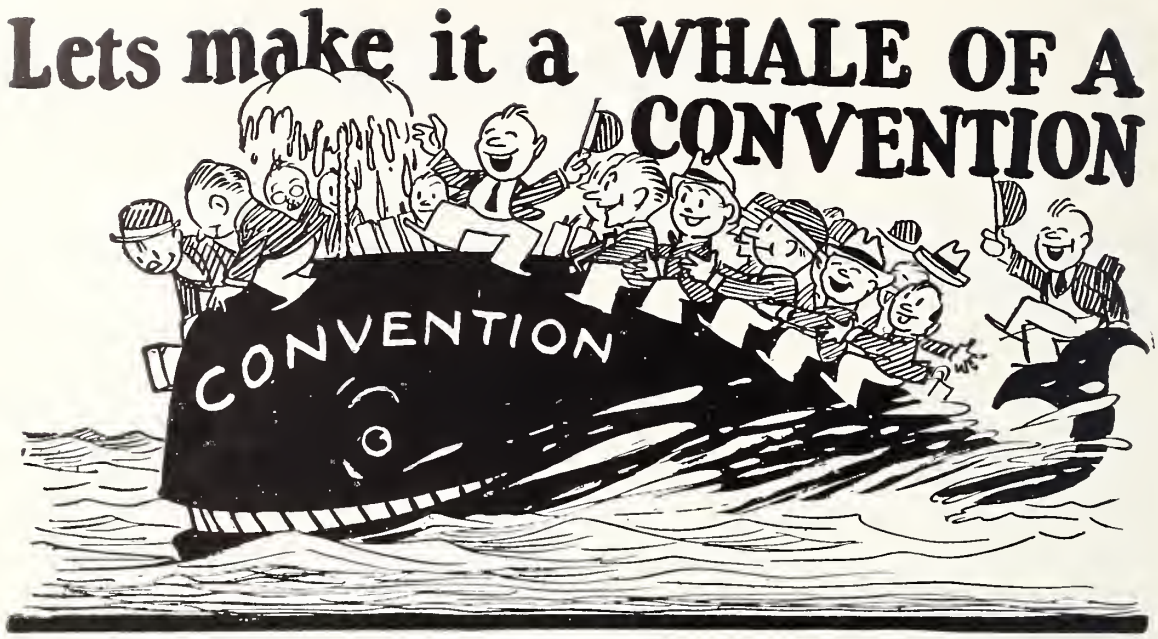
The blood clot in phlebothrombosis is the result of tissue injury and can become detached easily from the vein wall. These patients, although apparently not ill, are potential fatalities because of the danger that the clot will become detached and be carried by the blood stream to the lungs where it may act as a plug and cause death. Early detection of this condition is possible if the patient is examined for tenderness of the legs following any tissue damage such as an operation.

Cutting of the affected vein, which runs under the skin in the thigh, above the thrombus will prevent this clot from reaching the heart, suggest the physicians.

On the other hand, the blood clot in thrombophlebitis is the result of inflammatory changes and is firmly attached to the vein wall. This condition usually can be diagnosed easily from symptoms such as fever, pain and swelling. The patient's chances of recovery are good, but if he does not receive effective treatment, complications such as swelling, pain, ulceration of the legs and infection may develop.

Treatment of this condition, which the physicians say will effect a cure, consists of injecting a local anesthetic such as procaine hydrochloride or Bromsalizol into the sympathetic ganglions nerve centers which run alongside the spinal cord. In addition, the leg is elevated until the swelling disappears, which usually requires from three to ten days.

Drs. Aycock and Hendrick point out some of the factors which contribute to the development of venous thrombosis. Citing other investigators, the authors state that a greater incidence of the disease was found during the winter months, especially when grippal infections were most prevalent. Also, more cases have been reported in Northern states than in Southern states, which may be attributed to the greater incidence of the infections of the upper part of the respiratory tract in the northern section of the country. In addition, venous thrombosis has been found to occur more often in the older age group of patients and in patients who have cancer, heart disease and serious infections.



A "WHALE OF A CONVENTION" IS IN THE MAKING

Three full days of scientific discussion, instruction, and exhibits, including many new and special features, interlaced with an exceptional program of entertainment and ideal facilities for rest, relaxation, and good fellowship for the medical profession.

An intensive, up-to-the-minute postgraduate course, combined with all the facilities of an enjoyable vacation for the doctor and his family.

All Under One Big Top.

THE TIME: TUESDAY, WEDNESDAY, AND THURSDAY, OCTOBER 28, 29, AND 30, when the autumn grandeur of the southern Indiana hills is at its best.

THE PLACE: FRENCH LICK SPRINGS HOTEL—AMERICA'S GREATEST SPA. Things have been happening down at French Lick. The hotel is now under entirely new ownership and management. Thousands of dollars are being spent on new furnishings and decorations. Additional conference and committee rooms are being added. A large billiard and bowling casino is being built under the main convention hall. The old Pluto Bar on the first floor of the de luxe corridor (including its memorable aroma), is being replaced by a la petite cocktail lounge.

On the ground floor, directly under the main hotel lobby, the old barber shop and what was once the world's largest "hole-in-one comfort assembly" has been transformed into a beautiful air-conditioned restaurant and bar; featuring quick service and moderate prices, an informal rendezvous for good fellowship, providing food for the hungry, refreshment for the thirsty, and restoratives for the weary, at any legal and reasonable hour.

We anticipate and have been assured that there will be a marked improvement in the service and cuisine in the hotel's main dining rooms. The carpet in the large, east dining room has been replaced by a beautifully polished floor, suitable for dancing as you dine. New public address systems, motion picture projectors and screens are being installed, and additional A.C. electric power is to be provided for use of exhibitors and radio reception.

Many improvements to the hotel grounds, gardens, golf links, and airport are now under way and we believe that this year you will be thrilled by grand old French Lick with its face lifted. Pluto is still there but no longer olfactorily predominates the hotel.

RESERVATIONS AND RATES: Elsewhere in this issue of your JOURNAL you will find a complete listing of rates and accommodations of the French Lick Springs Hotel. The 1947 rates compare favorably with the rates of previous French Lick conventions.

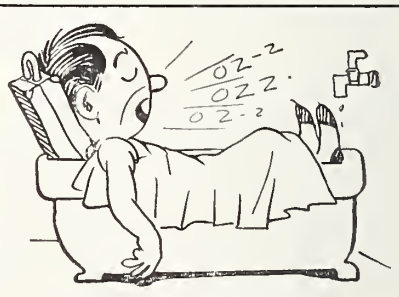
You will also find a list with rates of the other hotels and tourist homes in the Frenh Lick-West Baden district which have been approved by the Convention Arrangement Committee.

WARNING: Advance reservations now on hand indicate that most of the convention guests are planning to spend at least three full days at French Lick and some are requesting reservations for the entire week. There are indications of a complete sellout of all hotel and lodging accommodations for the convention this year, and we therefore advise you to make your reservations at once.

APOLOGY: We regret that our allotted space in this issue of THE JOURNAL will not permit us to tell you more about the "Whale of a Convention" that is in the making. This is the first of a series of convention previews which will appear in THE JOURNAL, June through October, under the auspices of Your hosts,

The Orange County Medical Society,
The Third District Medical Society,

Committee on 1947 Convention Arrangements:
Clarence E. Boyd and Augustus P. Hauss, co-chairmen; John K. Spears, William H. Garner, E. P. Buckley, Samuel W. Baxter, Herbert P. Sloan, and Mrs. James W. Baxter, Jr.



Do not let this happen to you.

Official List Of Hotel Accommodations, Rates, And Information

1947 Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick

OCTOBER 28, 29, AND 30

FRENCH LICK SPRINGS HOTEL

Convention Headquarters—600 rooms.

Rooms with bath for single occupancy—$13.00 daily.

Double rooms with bath, twin beds, in de luxe section ("A" section)—$12.00 per day, per person, when occupied by two.

Double rooms with bath, twin beds, main section, and all other outside locations, $11.00 per day, per person, when occupied by two.

Double rooms with bath, back of house, facing dining room, kitchen, and roofs, $10.00 per day, per person, when occupied by two.

Rooms with lavatory and toilet only, for single occupancy, $10.00 per day.

Double rooms, lavatory and toilet only, $9.00 per day, per person, when occupied by two.

Rooms with running water only, $8.00 per day, per person, whether occupied by one or two.

Room rates include all meals and special convention banquet. The charges are to be divided into quarter days so that there will be no charges for anything that is not actually received, and based on the following periods:

Arrival—Before 9:30 a.m.—full day.
After 9:30 a.m., before 2:30 p.m.—¾ day.
After 2:30 p.m., before 9:00 p.m.—½ day.
After 9:00 p.m.—¼ day.

Departure—(Means actual time of leaving, baggage out, rooms released).
After 7:00 a.m., before 11:00 a.m.—¼ day.
After 11:00 a.m., before 4:00 p.m.—½ day.
After 9:00 p.m.—full day.

West Baden Springs Hotel, formerly The Homestead, West Baden—92 rooms.

Double rooms with bath—$5.00 double; $3.00 single.

Double rooms with toilet (no bath)—$4.00 double; $2.50 single.

Double rooms with running water (no toilet or bath)—$3.50 double; $2.00 single.

(Food is not included in above prices).

New Harrison Hotel, West Baden—29 rooms.

Rooms without bath—$2.00 per person.

Doyle's Tourist Home, West Baden—14 rooms.

Rooms with bath on halls—$2.50 double; $1.50 single.

Pierce's Tourist Home, West Baden—6 rooms.

Rooms with bath on halls—$2.50 per person.

Claxton House, French Lick—20 rooms.

Rooms with bath on halls—$1.50 to $2.00 per person.

Grand Hotel, French Lick—30 rooms.

Rooms with bath on halls—$2.00 per person.

(Food is not included in any of the above prices).

A list of available rooms in private homes located in the French Lick-West Baden district is being compiled by the Convention Arrangement Committee. Address inquiries to Dr. C. E. Boyd, co-chairman, in care of French Lick Springs Hotel, French Lick, Ind.

Make Reservations Direct with the Hotel of Your Choice.

PROPOSED ADDITIONS TO AGREEMENT FOR MEDICAL CARE TO VETERANS

CHARLES F. THOMPSON, M.D.*

INDIANAPOLIS

IT IS quite important that physicians over the state who are rendering out-patient service to veterans in their communities be informed with regard to changes in administrative details of such care, additions or changes to the agreement with the Indiana State Medical Association, covering such care to veterans, and be reminded of errors in procedure and practice with regard to rendering care to veterans.

Under date of May 10, 1947, a revised fee schedule, which provides for uniform fees in the 38 states in which there are existing agreements covering out-patient service to veterans, was forwarded to county societies for acceptance, rejection, or correction. On the same date, the component societies of the state association were requested to submit a list of specialists from their membership. This is to comply with paragraph 8 in the agreement between the Veterans Administration and the state association, under which a list of such specialists was to be furnished the Veterans Administration for the purpose of special examination or treatments to veterans.

The following additions and changes in the original agreement between the Veterans Administration and the Indiana State Medical Association are in the process of being accepted for incorporation in the original agreement.

(1) Paragraph 9. An amendment providing for the designation of physicians by the Veterans Administration to examine beneficiaries for pension rating service rather than the choice of such examination remaining with the veteran.

(2) The addition of paragraph 15, providing for cancellation of the existing agreement by either the Veterans Administration or the Indiana State Medical Association upon thirty days notice.

(3) Termination of the present agreement on June 30, 1947, and the provision for renewal of such agreement upon request of the state association sixty days prior to such date, and acceptance by the Veterans Administration thirty days prior to the same date—June 30, 1947. A request for renewal has been forwarded by the state association.

Considerable difficulty has arisen from prescriptions written by designated physicians for medication to veterans for service connected disabilities. This misunderstanding has resulted in the inability to pay dispensing druggists for such prescriptions during the month of April, 1947, an aggregate sum in the neighborhood of $350. Additional information has been mailed to doctors clarifying this situation.

The following requirements are necessary in such procedure and will prevent much of this difficulty:

(1) The prescriptions must show NAME AND ADDRESS OF VETERAN, DATE PRESCRIPTION IS WRITTEN, SIGNATURE OF PHYSICIAN, and the statement that "I AM AUTHORIZED TO TREAT AND PRESCRIBE FOR ABOVE NAMED VETERANS ADMINISTRATION PATIENT."

(2) The prescription must be filled within ten days of the date upon which it was written. Prescriptions must not be written except during a current period in which there is written authorization to treat the veteran. Usually such authority covers only one month.

The former plan of obtaining necessary medication from the Veterans Administration Office at 36 S. Pennsylvania Street, Indianapolis, "Forward your prescription to this office with your recommendation for treatment—the medicine and necessary supplies will then be forwarded to the veteran for treatment of his SERVICE CONNECTED disability," is still in existence. Such prescriptions forwarded to the above office are limited to medication for a period of one month.

* Chairman, Veterans Committee.

Medical Panorama by the Associate Editor

WAYNE COUNTY (Michigan) reports refusal of city and county welfare boards to pay new minimum medical fees, and urges members to decline work for any governmental agency which refuses to meet the minimum schedule established by the Michigan State Medical Society. Rates listed in schedule are: Office, $3.00; home, $4.00; night, $6.00.

———— S I M A ————

DISTRICT OF COLUMBIA has appointed a panel of physicians, consisting of an appointee and an alternate in each specialty, upon whom representatives of the press may call to verify scientific information before it appears in newspapers.

———— S I M A ————

NEW YORK MEDICINE publishes the following "Narcotic Don'ts for the Physician":

Don't leave prescription pads around.
Don't write a narcotic prescription in lead pencil.
Don't write for narcotics this way: #10 or #X—use brackets or spelling.
Don't carry a large stock of narcotics in your bag.
Don't leave your bag in your car.
Don't store your office supply where patients can get at it.
Don't fall for a good story from a stranger claiming an ailment that usually requires morphine.
Don't give a narcotic prescription to another without seeing the patient.
Don't write for large quantities of narcotics.
Don't leave prescriptions signed in blank at the office for nurses to fill in.
Don't check your bag in a public place without first removing all narcotics.
Don't treat an ambulatory case of addiction.
Don't dispense any narcotics without keeping a record of it.
Don't buy your office narcotic needs on prescription blank in name of a patient.
Don't resent a pharmacist's call for information about a prescription you may have written.
Notify Police Department and Federal Bureau of Narcotic Control in event of any difficulties or suspicion of a narcotic addict.

———— S I M A ————

COSMOPOLITAN magazine, May issue, has a "must" for reading for doctors. Read "Dr. Wilder's Dilemma."

FULTON COUNTY (Georgia) "held its monthly dinner meeting at the Academy of Medicine, Atlanta. Scientific program: Ischiopagus Agonoides Tripus, Case Report. . . ." Hm-m-m-m!—besides Governors?

———— S I M A ————

CONNECTICUT, in appointing a committee to study the organization and objectives of their society, will seek to evaluate the construction, machinery, and production of their Society, "from the standpoint of today's efficiency and of tomorrow's progress." They will survey their council, financial operations, committee operations and responsibilities, education purposes, public relations, legislative policies and relationship with county organizations.

———— S I M A ————

PHILADELPHIA MEDICINE suggests two effective ways to combat the threat of trade unionism in medicine. Stimulate the action of Congress in repealing existing labor laws and policies. Secure the passage of a stringent law by the A.M.A. House of Delegates requiring immediate expulsion from organized medicine of any member who joins a trade union.

———— S I M A ————

ORLEANS (LOUISIANA) Parish — the Deep South, that is—comes up with a dilly in public relations. Recommended by their Judiciary Committee: No more bulletins to the local press or non-medical organizations. No more press releases. No mention of members reading papers at conventions, or election to medical offices, or staff membership. What modesty!

———— S I M A ————

TEXAS, reporting the application for an incorporating charter of the San Antonio Medical Foundation, indicates that, after long months of planning, activity will now be directed toward "securing an outstanding medical authority to make a detailed survey of the health needs of San Antonio." Sponsored and organized by the local Chamber of Commerce, "the foundation is exclusively for benevolent, charitable, and educational purposes, and will be concerned with promotion of facilities for medical, dental, and nursing education, hospitalization and treatment of the sick, and medical and dental research."

DISTRICT OF COLUMBIA is considering the advisability of adopting an indoctrination program in the principles of medical organization, health insurance, public relations, ethics, education, economics, and malpractice, similar to the required course for membership in Los Angeles County Medical Society.

———SIMA———

AMERICAN HOSPITAL ASSOCIATION plans an intensive nurse enrollment program throughout 1947. Direct aid to hospital schools of nursing from a national publicity campaign is under way and schools of nursing and other interested organizations, affected by the shortage, are asked to contribute financial help. National foundations and agencies, and medical and nursing organizations are co-operating, and a strong committee is directing the enrollment drive.

———SIMA———

MINNESOTA editorializes the nursing problem and suggests, as a solution, "the establishment of nurses' training courses in properly equipped rural hospitals, with one-year affiliation in the large city hospital." Reasons: taking the course to the source of supply and providing ways for self-help and equal opportunity.

———SIMA———

JOURNAL-LANCET (Minnesota, North Dakota, South Dakota, and Montana) discusses the postwar problems of hospitals. Lack of hospital accommodations due to deferred construction, education of public to increased use of hospitals, new methods of patient care, and growth of prepaid hospitalization plans are the major problems. Indications are that 195,000 additional beds are needed but shortages of materials and equipment and high construction costs are holding up any appreciable increase in the number of beds.

Insufficiency of nursing personnel due to large number required in veterans hospitals, increase of 60 per cent in five years of hospital admissions, decrease in working hours and increase in vacations, sick leaves and holidays, necessitating more nurses.

The establishment of policies directed toward improved medical staff organization and the problem of freedom of licensed physicians to use hospital facilities.

The rapid development and severity of the rise in cost of hospital operation. These costs increased more than 50 per cent in the past three or four years and have now passed the equalizing factors of increased volume of bed occupancy, high incomes, minimum unemployment, and participation in prepaid plans.

These problems present a definite challenge to hospital administrators and medical staffs in maintaining efficient, economical, and capable service to their communities.

OHIO advocates passage of Senate Resolution 61 which authorizes and directs a subcommittee of the Senate Committee on Labor and Public Welfare to make a study and investigation of Federal grants to state and local governments for welfare, education, and health problems. They feel that many of these grants-in-aid programs "have become nothing less than a racket. They are shot through with duplication, waste, and inefficiency." They consider them poorly administered, abused by state and local governments, used for propaganda purposes and obnoxious, dictatorial bureaucracies. They suggest that: "If you would like to see this mess which has been building up at Washington for years thoroughly checked and renovated, drop a line to Senator Robert A. Taft, Ohio's Senior Senator, who is Chairman of the Senate Committee on Labor and Public Welfare. Tell him why you think an honest, unbiased investigation of this kind would serve a useful and worthy purpose."

———SIMA———

MANY STATES, counties and cities, in their respective Journals and Bulletins, are devoting a great deal of space to the subject of the Specialty Boards. Practically all of them decry the activities of board diplomates in attempting to control hospital appointments and otherwise dominate the economic welfare of fellow practitioners. The volume of protest is swelling and the demand is increasing for a safe and sane return to a fundamentally sound basis for specialty certification and an appropriate understanding and recognition, on an equal level, of the general practitioner.

———SIMA———

AMERICAN COLLEGE OF RADIOLOGY has adopted this essential statement of policy regarding ownership of roentgenograms:

1. Films should be used for best interest of patient.
2. Films are legal property of radiologist or hospital.
3. Films and report should be available to physician referring patient.
4. Films removed by physician or patient are "on loan" and should be returned.
5. Change in physician should not alter availability of films and report to second physician.
6. Objection to submission of films and report to second physician must be overruled by radiologist.
7. All films must be permanently and plainly marked for identification and date.
8. Radiologist has right to refuse films in medicolegal situations except on court order.
9. Liberal attitude regarding release of films to patient or physician is advocated.
10. These principles are deemed equally applicable to roentgenograms made by physicians other than those engaged in radiology as a specialty.

What's Going On In Indiana by the Executive Secretary

Registration Procedure. The State Board of Medical Registration and Examination is setting up machinery for registration of all of its licensees as provided by a 1947 amendment to the Medical Practice Act. Meantime, doctors should wait until the board notifies them that it is ready. Notices will be mailed to physicians with a request for their remittances sometime between June 10 and 15. The fee is $5 per year for doctors practicing within Indiana and $10 for those living outside the state. The fee becomes due July 1, and is payable up to and including August 31 without penalty. After the deadline all licensees who failed to register will lose their licenses automatically. They may be reinstated by payment of the overdue fee plus $10 penalty. As a result of the new law the state will have a record of practitioners of the healing arts for the first time, and the board will have funds for prosecution of illegal cultists.

——ISMA——

Recruiting for Nursing Schools. One way to get more nurses is to get more girls to enter nursing training, is the decision of the Committee for Study of Nursing Service of the Indiana State Medical Association. Not a new idea, of course, but a new activity for a state medical association committee. A list of the opportunities offered young women in the nursing field was drafted by the committee and copies mailed to councilors. The councilors, in turn, were asked to designate doctors in various communities of their districts to contact high school seniors and sell them on nursing as a career. It is too early to tell whether this campaign did any good, but it shows that the medical profession is concerned about the nurse shortage, and, moreover, is trying to do something about it!

——ISMA——

What Kind of Meetings? Dr. Harry E. Klepinger of Lafayette, president of the Indiana Board of the General Practice of Medicine, has been arranging monthly postgraduate courses of a half day's duration. He has been at a loss to know what kind of programs would please the majority of the board members, so he decided to find out. Doctor Klepinger prepared a comprehensive questionnaire. The questions cover all angles of postgraduate programs, even as to the hour they should start and the time they should end. Questionnaires were mailed to board members, officers of the state medical association, and many other doctors throughout the state. When the returns are tabulated Doctor Klepinger should have the answer to his problem. The opinions collected, too, should serve as a guide for all medical program committees.

Most Active Committee. The Bureau of Publicity is without question the hardest working committee of the state association. With few exceptions the members meet at state headquarters office every two weeks. They go over all association news releases to daily and weekly papers. The bureau selects the radio transcriptions offered by the Bureau of Health Education of the A.M.A. for the weekly radio program (Mondays, 2:45 p.m. to 3 p.m., WFBM, Indianapolis). All printed matter issued over the name of the medical association is first approved by the bureau. All requests for speakers, too, are referred to the Bureau of Publicity, and efforts are made to get doctors to address various types of organizations, from county medical societies down to neighborhood Parent-Teacher Associations. Another duty of the bureau is that of serving as an advisory committee to the Woman's Auxiliary. The Bureau of Publicity was established in the fall of 1922, the first members being Drs. William N. Wishard, F. W. Cregor and David Ross, all deceased.

——ISMA——

Medical School Scholarships. The establishment of medical school scholarships by the Indiana State Medical Association brought nation-wide recognition to Indiana medicine. The Michigan State Medical Society asked for details. The Journal of the American Public Health Association carried an article about the action, and mention has been made in many of the state medical journals. The Committee on Medical School Scholarships has issued a booklet about the scholarships for distribution among pre-medic students, and application blanks and recommendation forms have been printed. The first of the scholarships will be awarded this summer, effective at the beginning of the 1947-48 school year. The state association has appropriated $3,000 annually for the scholarships. Contributions from outside sources are acceptable, and it is hoped that philanthropic-minded business organizations and individuals will swell the fund by their contributions. Upon completion of his internship a recipient of the scholarship must practice for five years in some community where medical service is needed. By doing this the doctor will fulfill his part of the contract, and will not have to repay the money advanced to him, which could be as much as $2,000.

The scholarship project should be helpful in supplying doctors for rural areas which do not have adequate medical services. The press has commented favorably upon the medical association itself taking this step to alleviate the physician shortage.

News Notes

After forty-nine years of practice, Dr. John H. Baldwin has retired from professional life, according to a recent announcement. Dr. and Mrs. Baldwin have been in Fort Lauderdale, Florida, during the winter season, but plan to retain their Jeffersonville home.

Following separation from service in December, 1946, Dr. Marvin P. Cuthbert has opened an office at 203 Hume Mansur Building, Indianapolis, for the practice of ophthalmology. During his two years' service in the Army, Doctor Cuthbert spent most of his time at Vaughn General Hospital, Hines, Illinois, and Camp McCoy, Wisconsin, where he was chief ophthalmologist, and Camp Carson, Colorado, where he was commanding officer of the hospital. He also was associated with the Scientific Research and Development Department, United States Government, where he did research on war gas before entering the Army.

Dr. Charles F. Deppe, formerly of Franklin, plans to open an office in Edinburg for the practice of medicine in the near future. He was very recently discharged from the service after four years of active duty with the Navy. While aboard an aircraft carrier, the *U. S. S. Monterey*, Doctor Deppe participated in the invasions of the Gilberts, the Marshalls, Hollandia and New Guinea, and the Marianas, and in air strikes at Kavieng (New Ireland) Truk, the Marianas, and Iwo Jima, before being transferred to the *U. S. S. Hovey*, a destroyer mine-sweeper. After numerous engagements this ship was sunk due to enemy action at Lingayen Gulf, on January 6, 1945. The crew was picked up by a sister ship and returned to the United States. Doctor Deppe then spent six months at the Naval Hospital at Bainbridge, Maryland, and ten months in the separation centers at Bremerton, Washington, and Minneapolis, Minnesota, where he did photofluorography. He was then transferred to the Naval Air Station at Jacksonville, Florida, where he was discharged after six months duty at the dispensary there.

Dr. Arthur A. Hobbs, Jr., formerly of Ogdensburg, New York, is now associated with the Protestant Deaconess Hospital, in Evansville, as radiologist.

After a year as chief resident surgeon at the Methodist Hospital in Indianapolis, Dr. G. K. Hammersley has resumed practice in Frankfort, at 361 East Clinton Street.

THE JOURNAL congratulates Dr. Oscar S. Heller, of Greenfield, who celebrated his fiftieth year of practice of medicine on April first.

At a recent meeting of the American Association of Governmental Industrial Hygienists quite an honor was conferred upon Indiana, and upon Dr. Louis W. Spolyar, of Indianapolis, when he was elected president of the association. Doctor Spolyar is director of the Division of Industrial Hygiene at the Indiana State Board of Health.

Narcotic License Renewal Due July First

Physicians registered under the narcotic law are reminded that their re-registration form 678, their inventory form 713, showing drugs on hand, and their annual tax of one dollar must be in the office of the Collector of Internal Revenue on or before July first.

The Joint Committee on Occupational Ophthalmology is anxious to contact all ophthalmologists who are interested in industrial eye problems.

By interest in industrial eye problems is meant any single phase, or all phases, such as: interest in medical or surgical eye care; interest in guiding industrial eye programs for industry; interest in doing industrial eye work within a plant; acting as consultant in the setting up of an eye protection program; guiding a study of eye hazards, near point problems, corrective programs.

Anyone interested should contact Dr. Hedwig S. Kuhn, Secretary of the Joint Committee on Occupational Ophthalmology, 112 Rimbach Street, Hammond.

Annual Session, American Congress of Physical Medicine

The American Congress of Physical Medicine will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6, inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. For information concerning the convention address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Prize Contest Announcement

The Central Association of Obstetricians and Gynecologists offers two $100 annual prize awards to any accredited physician, research worker, or medical student within the confines of the Central Association. One award is for the best clinical work and the other for the best investigative work in the field of obstetrics and/or gynecology. Papers submitted for either of these awards must be in the hands of the secretary not later than August 15, 1947. Dr. J. I. Brewer, 104 South Michigan Avenue, Chicago, is secretary of the association.

Approximately 150 physicians from Ohio, Kentucky, Illinois, Iowa and Indiana attended a meeting of the newly-formed Indianapolis Obstetrical and Gynecological Society held in Indianapolis on April ninth. The guest speakers were Dr. Floyd T. Romberger, president of the Indiana State Medical Association, Lafayette, whose subject was "How to Obtain an Obstetrical-Gynecological Section in the State Medical Association," and Dr. Frederick H. Falls, professor of Obstetrics and Gynecology, University of Illinois, Chicago, who spoke on "Ectopic Pregnancy—Etiology, Diagnosis and Treatment."

Dr. Frederick L. Kuhn has opened an office at 1215 South Michigan Street, South Bend, for the practice of general medicine. Dr. Kuhn served three years in the Army Air Forces as a flight surgeon, stationed in the Philippine Islands and Japan.

After having completed a year of graduate study at the St. Louis University Hospital, Dr. John Miklozek has announced the opening of an office at 1461 South Seventh Street, Terre Haute. Doctor Miklozek served for four and one-half years with the First Armored Division of the United States Army and was stationed in the Mediterranean theatre. He was discharged from service May 8, 1946, with the rank of major.

THE JOURNAL regrets to announce that Patricia Fox, daughter of Dr. Maurice Fox, of Vincennes, was killed in a traffic accident in Indianapolis on May seventeenth. Miss Fox was a junior at Butler University, and was residing in Indianapolis. She was twenty-one years of age.

Dr. E. A. Porter, of Westport, has recently been appointed Decatur County coroner.

Dr. Dean B. Jackson, formerly of Fort Wayne and Angola, has announced his association with Dr. J. W. Morris, of Hartford City, in the practice of general medicine and surgery. Doctor Jackson served for five years in the United States Navy as a medical officer.

Captain John J. Mahoney, former executive officer of the 32nd General Hospital, sponsored by the Indiana University Medical Center, has been named assistant to the dean of the Indiana University Medical Center, in Indianapolis, and as assistant professor of experimental medicine.

Dr. Norman M. Silverman, formerly of Riley, who has recently returned from four years' service as a transport surgeon in the armed forces, has opened an office for the practice of general medicine, at Seventh and Hulman Streets, Terre Haute.

Dr. Donald E. Stephens, an ex-navy officer, has opened an office for the practice of general medicine, in the Carter Building, 6332 Guilford Avenue, in Indianapolis.

Dr. W. R. Tindall, of Shelbyville, has been appointed as city health officer, succeeding Dr. W. R. Gehres.

Dr. Robert H. Maschmeyer, formerly of Shelbyville, has located in Shoals, in the Opera House, for the practice of general medicine.

Announcement has been made of the appointment of Dr. John W. Ferree, formerly director of the Division of Educational Services, American Social Hygiene Association, as associate executive director of the National Health Council, New York.

On May twenty-second a staff meeting was held at the St. Francis Hospital, in Indianapolis, to inaugurate the opening of an x-ray therapy department. Dr. J. William Wright, president of the Indianapolis (Marion County) Medical Society, Dr. B. C. McCullum, of Fort Wayne, and all Indianapolis radiologists and residents in radiology in Indianapolis hospitals were invited to the dinner meeting. Preceding the dinner Dr. J. N. Collings, of Indianapolis, gave a paper on "X-ray Therapy," which was discussed by Dr. John A. Campbell, also of Indianapolis.

Deaths

Clarence F. Kercheval, M.D., of Wolcottville, died April second at the home of his son, Dr. J. M. Kercheval, at Clinton, following a long illness. Doctor Kercheval was seventy-four years of age. He graduated from the Illinois Medical College, in Chicago, in 1898, and had practiced medicine in Decatur County until 1925. For several years he had been associated with his son in the practice of medicine in Clinton.

William J. Norton, M.D., of Columbus, died April twenty-fifth, at the age of eighty-two years. Doctor Norton graduated from the Lincoln Memorial University Medical Department, in Knoxville, in 1894, and for half a century had practiced medicine in Bartholomew County. He was an Honorary member of the Bartholomew County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Ora L. McCay, of Romney, died April seventeenth, at his home, following a long illness. He was sixty-seven years of age. Doctor McCay graduated from the Medical College of Indiana, in Indianapolis, in 1904. He had served as a captain in World War I. Dr. McCay was a member of the Tippecanoe County Medical Society, of which organization he was a past president, the Indiana State Medical Association, and the American Medical Association.

Charles F. Murphy, M.D., of Cynthiana, died April twenty-third, after an extended illness. He was seventy-four years of age. Doctor Murphy graduated from the Louisville Medical College in 1894. He had retired from active practice two years ago.

Books

RECEIVED

PRACTICAL PHYSIOLOGICAL CHEMISTRY (Twelfth Edition). By Philip B. Hawk, Ph.D., President, Food Research Laboratories, Inc., Long Island City, New York; Bernard L. Oser, Ph.D., Director, Food Research Laboratories, Inc., Long Island City, New York, and William H. Summerson, Ph.D., Associate Professor of Biochemistry, Cornell University Medical College, New York City. 1323 pages. Cloth. Price $10.00. The Blakiston Company, Philadelphia, 1947.

RADIOLOGY FOR THE MEDICAL STUDENT. By Fred Jenner Hodges, M.D., Professor and Chairman, Department of Roentgenology, University of Michigan; Isadore Lampe, M.D., Associate Professor, Department of Roentgenology, University of Michigan; John Floyd Holt, M.D., Assistant Professor, Department of Roentgenology, University of Michigan. 424 pages. Fabricoid. Price $6.75. The Year Book Publishers, Inc., 304 S. Dearborn Street, Chicago 4, 1947.

THE EGO AND THE MECHANISMS OF DEFENCE. By Anna Freud. 196 pages. Fabricoid. Price $4.00. International Universities Press, Inc., New York, 1946.

THE STORY OF HUMAN BIRTH. By Alan F. Guttmacher, M.D., Associate Professor of Obstetrics, Johns Hopkins University, Baltimore, Maryland, 224 pages. Paper. Price 25c. Penguin Books, Inc., 245 Fifth Avenue, New York, 1947.

THE YEARBOOK OF PSYCHOANALYSIS, (Volume II). By Editorial Board, International Universities Press, New York. 280 pages. Cloth. Price $7.50. International Universities Press, New York, 1946.

THE CHEST. A Handbook of Roentgen Diagnosis. By Leo G. Rigler, M.D., Professor and Chief, Department of Radiology, University of Minnesota. 352 pages with 338 illustrations. Cloth. Price $6.50. The Year Book Publishers, Inc., Chicago, 1946.

REVIEWED

HYGIENE. By Florence L. Meredith, M.D., Professor of Hygiene and Public Health, Tufts College, Boston, Massachusetts. (Fourth edition.) 838 pages with 155 illustrations. Cloth. Price $4.00. The Blakiston Company, Philadelphia, 1946.

Usually these texts are far behind latest advances in physiology and clinotherapy but this one is up to date with the recent progress. Its best claim to praise is its readability, and it should be required reading for any and every degree in college. Its wide perusal would prevent many grievous mistakes which cost life and health. As a gift to your more intelligent patients it would inform them on how to choose their physician and how to treat him with understanding of his professional ethics. Such sound advice on this subject is rarely to be found in the available literature.

Charles N. Combs.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 13, 1947.

The Council of the Indiana State Medical Association convened for its spring meeting at 10:10 A.M., Sunday, April 13, 1947, in the Columbia Club, Indianapolis, with Dr. Alfred Ellison, chairman, presiding. Roll call showed the following present:

Members of the Council:

First District—I. C. Barclay, Evansville
Second District—J. H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Fourth District—C. F. Overpeck, Greensburg
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—Not represented
Eleventh District—C. S. Black, Warren
Twelfth District—Paul A. Garber, South Whitley
Thirteenth District—Alfred Ellison, South Bend

Officers:

Floyd T. Romberger, LaFayette, president
Cleon A. Nafe, Indianapolis, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
E. M. Shanklin, Hammond, editor of THE JOURNAL
N. K. Forster, Hammond, associate editor of THE JOURNAL
C. H. McCaskey, Indianapolis, chairman, Executive Committee
W. L. Portteus, Franklin, member, Executive Committee
Albert Stump, Indianapolis, attorney
Ray E. Smith, Indianapolis, executive secretary

Guests:

Thurman B. Rice, Indianapolis, I. U. School of Medicine
O. A. Province, Franklin, chairman, Committee on Scientific Work
J. William Wright, Indianapolis, co-chairman, Legislative Committee

On motion of Drs. Mitchell and Garber, the minutes of the midwinter Council meeting held at Indianapolis on January 12, 1947, were approved as printed in the March, 1947, issue of THE JOURNAL.

Special Announcements

The chairman announced that mimeographed copies of Chapter VII of the By-Laws of the state association, pertaining to the Council, were being distributed to the councilors in order that they might refresh their memories on their duties and obligations as members of the Council.

Reports of Councilors

District meetings were reported scheduled as follows in May, and the councilors extended invitations to the state association officers, members of the Council, and all members of the association to attend these meetings:

1st District—Princeton Country Club Princeton, May 22.
3rd District—New Albany, May 28.
4th District—Seymour, May 14.
5th District—Deming Hotel, Terre Haute, May 2.
6th District—Richmond, May 8.
9th District—Attica, May 15.
11th District—Huntington, May 21.
12th District—Fort Wayne, May 6.

Dr. Hauss discussed the survey made in the Third District to determine the number of licensed and unlicensed cults in the district and the extent of their activities. He said he felt this is a field in which the Council should be aggressive. Information thus obtained should be compiled and given to the State Board of Medical Registration and Examination.

Dr. Hauss also spoke of the limited facilities in Indiana for holding the annual session of the state association, saying that French Lick and Indianapolis are practically the only cities in Indiana where accommodations are near adequate. "In view of this fact and knowing that some precedent had been established by other state medical societies in holding conventions outside of the state, I submitted a letter to Dr. Forster because he is in Lake county and adjacent to Chicago, and one or two other men in the state, just to get their reaction. This is the letter:

"I am submitting a half baked idea of mine to get your reaction.

"You know that our state medical conventions have practically outgrown every location in the state except French Lick and Indianapolis. The facilities in these two places are not everything to be desired.

"I believe that interest in our annual meetings will eventually decline unless we present some innovations.

"On two occasions in recent years the Southern Medical Society has stepped across the Mason-Dixon Line and held their annual meetings at Cincinnati, Ohio, but under the sponsorship of the Kenton County, Kentucky, Medical Society. The Kentucky State Medical Society is also planning to step over their boundary lines by holding their 1948 convention in Cincinnati, Ohio. The by-laws of the Kentucky association specifically provide that their business meetings be held in Kentucky but I am informed that they plan to call to order their House of Delegates in Covington, Kentucky, and then adjourn to a meeting place across the river in Cincinnati.

"I can find nothing in our constitution or by-laws that states that our meetings must be held in Indiana, so we would not have to use any subterfuge to hold our annual meeting outside the state.

"I have in mind three possibilities for a meeting outside the state:

Chicago, Illinois, under the auspices of the Lake County Medical Society and/or the Tenth District.

Cincinnati, Ohio, under the auspices of the Dearborn-Ohio County Medical Society and/or the Fourth District.

Louisville, Kentucky, under the auspices of the Floyd and Clark County Medical Societies and/or the Third District.

"We might also consider the feasibility of holding a joint Indiana-Illinois meeting in Chicago, an Indiana-Ohio meeting in Cincinnati, and an Indiana-Kentucky meeting in Louisville. We could have joint entertainment, banquets, and scientific meetings, but hold separate meetings of the Councils, House of Delegates, etc.

"This is just a brain storm of mine, so talk it over with some of the boys in your district and then tell me frankly what you think of it.

"Yours sincerely,

"A. P. Hauss,

"Councilor, Third District.

"P. S. Regardless of the place of the meeting, I think the place and dates of our annual meeting should be set two years in advance in order to assure better convention facilities and less conflicts with other conventions."

"I submit that just as an idea for the future. I do this because I definitely feel that our annual meeting dates should be set two years in advance."

Reports of Officers

DR. ROMBERGER, president: I believe that the councilmen are all well informed by our executive headquarters. The headquarters office is running smoothly. The Tenth District had a most enjoyable meeting at Schererville last week. We intend to make these district meetings as listed here. We hope there will be no conflicts. So far as I know everything in the state association is in ship-shape condition.

DR. WEYERBACHER, treasurer, called attention to the financial statements prepared by the George S. Olive and Company, certified public accountants, and carried in the March, 1947, JOURNAL. He reported that the average income on general fund holdings is 3.158 per cent, while the medical defense holdings yield 2.916 per cent.

DR. SHANKLIN, editor of THE JOURNAL: THE JOURNAL, I think, is in the best condition that it has been in the fifteen years that I have been connected with it. As a result of some changes made in the headquarters organization we have 100 per cent cooperation with the front office folks. Right now we have a backlog of papers, all good material, that will enable us to carry on for some time.

DR. MITCHELL, retiring chairman of the Council: I want to thank you for all your cooperation during my term as chairman of the Council. I was given a new job, and if I can get as much support in it as I have had from you gentlemen in the past, I will be quite happy.

Unfinished Business

1. *Mutual Medical Insurance, Inc.* Dr. Kennedy reported on the continued success of the company, saying that it had averaged about 200 new members per day last month and the income now is almost $700,000 a year. Dr. Kennedy continued, "The most important thing is that we are carrying out our original intentions of spreading out the benefits. We have added to our contract some sixty new features that were not found in our original policy."

2. *Committee for the Study of Nursing Service.* Discussion by Dr. Clark, chairman of the committee, Drs. Kennedy, Ellison, Hauss, Forster, Nafe and Mr. Stump, resulted in the motion by Drs. Clark and Hauss that each councilor appoint physicians in his district who are able and capable of going to the high schools and giving talks in which they appeal to the girls to enter nurses' training. The Committee for the Study of Nursing Service is to compile a list of arguments to be used in speaking before high school groups, these lists to be mimeographed and distributed through the councilors.

3. *Medical Care of Veterans.* Dr. Charles F. Thompson, chairman of the Veterans Committee, reported that two problems in connection with the program for care of veterans in their communities had come before the Veterans Committee and had not been disposed of because the committee felt it timely, since the Council was meeting, that these questions be brought to the attention of the Council for its consideration and action.

(1) Names of specialists in the various communities who will be used by the Veterans Administration for consultative work. It is the responsibility of the state association to submit the list of such specialists.

On motion of Drs. Mitchell and Clark the Veterans Committee was empowered to write to the various county medical societies requesting lists of specialists in their counties. This procedure will enable the Veterans Committee to compile the required list.

(2) Revision of the fee schedule in an attempt to establish a uniform fee schedule in the thirty-eight states which are now rendering outpatient service to veterans in the respective communities. Dr. Thompson explained that the basis for revision of the fee schedule is two-fold:

a. Recent reduction of appropriation to the Veterans Administration and careful investigation of the way the Veterans Administration is spending its appropriation.

b. The Veterans Administration has been accused of paying fees which are not consistent with fees charged for similar service rendered in the community.

On motion of Drs. Mitchell and Clark the Veterans Committee was instructed to submit the new fee schedule to the county medical societies for their approval, with the notation that the Council at its April 13, 1947, meeting had gone on record as approving this fee schedule.

4. *Report of Scholarship Committee.* Dr. Clark, chairman of the Scholarship Committee, asked for suggestions from the councilors on the "Declaration of Trust" which has been drawn up to cover the procedure to be followed by the state association in awarding scholarships. He called attention to the fact that:

(1) A recipient of a scholarship must be a resident of Indiana;

(2) The recipient must have been accepted by the medical school of his choice, which does not necessarily have to be an Indiana college, and

(3) If the recipient does not fulfill his contract by living in the community the specified length of time, he will be required to repay the scholarship on a pro-rated basis.

There being no objection to the "Declaration of Trust" it was considered as approved by consent.

5. *Examination of food handlers and signing of certificates.* The editor of THE JOURNAL was instructed to prepare an editorial on this subject.

1947 (98th) Annual Session at French Lick, Tuesday, Wednesday and Thursday, October 28, 29, 30, 1947

Dr. Hauss, co-chairman of the Convention Arrangements Committee, spoke of the extensive improvements which are being made by the new owners in the French Lick Springs Hotel, and of the plans of his committee to make the 1947 session the best ever held. Technical exhibits will be housed on the mezzanine floor of the hotel, while the foyer to the main convention hall will be reserved for scientific exhibits. To increase interest in this phase of the convention, awards will be made for the outstanding scientific exhibits. Preliminary plans of the convention arrangements committee include:

(1) Trap and skeet shoot and golf tournament on Tuesday, with adequate prizes;

(2) A "get-acquainted" frolic on Tuesday evening, for physicians, their wives and guests;

(3) General scientific meeting Wednesday morning, and section meetings Wednesday afternoon;

(4) Wednesday night open for committee dinner meetings, fraternity and class reunions and ex-servicemen's get-togethers;

(5) General scientific meetings Thursday morning and afternoon.

(6) Annual banquet and adjournment Thursday night.

Instructional courses are scheduled to begin at 11 o'clock Tuesday and continue until 5 o'clock Tuesday afternoon.

The House of Delegates will meet at 4 P.M. Tuesday and again at 11:30 A.M. Thursday.

The Council will meet at 12:30 P.M. Tuesday and following adjournment of the House of Delegates on Thursday.

Dr. Province, chairman of the Scientific Work Committee, outlined in detail the scientific program as arranged by his committee at its meeting on March 30.

On motion of Drs. Mitchell and Clark, the program as prepared by the Scientific Work Committee and the Convention Arrangements Committee, including holding the banquet on Thursday night, was approved and accepted by the Council.

Legislative Matters

Dr. Wright, co-chairman of the Committee on Public Policy and Legislation, reported on the activities of his committee during the 1947 session of the General Assembly, and spoke of the work to be done by the committee in the next two years. The chairman of the Council, on behalf of the members of the Council and the profession of Indiana, extended a vote of thanks to the Legislative Committee for the time and effort it had given to matters of interest to the association during the legislative session.

New Business

1. *Distribution of disease and medical service.* Dr. Thurman Rice, professor of Public Health, Indiana University School of Medicine, presented to the Council his ideas for setting up in his department at the medical school an agency for compiling public health information and statistics on the distribution of medical service and disease in every county and community in Indiana. He stated that no provision is made by the State Board of Health for securing this information and keeping it current. The project would be financed by funds from an outside source which he said he was reasonably sure he could obtain. Dr. Rice stated he felt this would be valuable data to have on hand and it would be information that would be useful to the profession of the state. It would be valuable to physicians in the preparation of papers, or to those who are seeking locations in which to practice. The project would be undertaken only with the approval of the state medical association and under the sponsorship of an advisory committee from the Indiana State Medical Association. Before actually beginning the work Dr. Rice would put in writing his plan and send a copy to each councilor. He stressed the fact that this agency would be responsible for only objective data, and the principal purpose of the project would be to get physicians in the right places.

On motion of Drs. Mitchell and Barclay the Council is to be supplied with information by Dr. Rice in order that this subject may be discussed at the next meeting of the Council.

2. *Nominations for Editorial Board:*

Dr. Clark nominated Dr. Kenneth G. Kohlstaedt, Indianapolis.

Dr. Mitchell nominated Dr. O. O. Alexander, Terre Haute.

Dr. Crowder nominated Dr. J. T. Oliphant, Farmersburg.

3. *Resignation of Dr. George Collett, alternate delegate to the A.M.A.* The secretary read the following letter from Dr. Collett:

"Since December I have been located at Elko, Nevada, where I have become associated with the Elko Clinical Group. . . . I should like to take this opportunity to tender my resignation as alternate delegate to the A. M. A. It is probable that someone should be appointed to take my place before the next convention.

"It is with mingled feelings that I contemplate the distance that separates me from my many friends in Indiana. I treasure more than I can tell you the memory of the fine fellowship that has been mine for the past twenty-one years in Hoosierland."

Dr. N. K. Forster of Hammond was elected alternate delegate to fill Dr. Collett's place. (Term expires December 31, 1948.)

4. *Nursing homes.* The manner in which nursing homes operate, and the rules and regulations concerning the operation of these homes, were discussed. Dr. Clark said, "Conditions in most of the nursing homes are very deplorable. I think it is time we interested ourselves in seeing that something is done to protect people who have to go to these homes. The nursing home is a fine thing if it is run properly." The attorney for the association is to look up the laws regulating the management of these institutions and report later to the Council.

5. *Public Relations.*

a. *In other states.* For the information of the Council the executive secretary explained the public relations programs which are being carried on by the Michigan, Ohio, and Oklahoma state medical societies.

b. *In Indiana.* Following discussion by Drs. Mitchell, Nafe and Hauss, Dr. Mitchell made the motion, which was seconded by Dr. Clauser and passed, that the Council sanction the establishment of a postgraduate course of one day, to be set up in different parts of the state, the program to be scientific and economic. This motion is to be referred to the Committee on Public Relations of the association for activation, and this committee is to report to the Executive Committee on requirements, plans of procedures, et cetera.

6. *Hospitalization of patients for diagnostic purposes.* Dr. Ellison spoke of the practice of hospitalizing patients for x-ray examinations and other laboratory work which could be done without hospitalization. In many cases this is done for the sole reason that most insurance contracts provide for payment for such laboratory procedures in the event the patient is hospitalized for eighteen or more hours. As a result an acute shortage of hospital beds exists. "I am sure that physicians who do this are unmindful of the fact that they are taking part in a shady deal," Dr. Ellison concluded. The Council took no action on this matter.

7. *July meeting of Council.* By consent the next meeting of the Council was set for Sunday, July 20, 1947.

There being no further business, the meeting was adjourned.

RAY E. SMITH,
Executive Secretary.

EXECUTIVE COMMITTEE

April 12, 1947.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Floyd T. Romberger, M.D.; Cleon A. Nafe, M.D.; Walter L. Portteus, M. D.; Alfred Ellison, M.D.; E. M. Shanklin, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; and Ray E. Smith, executive secretary.

Guest: Charles F. Thompson, M.D., chairman, Veterans Committee.

It was decided by common consent that officers should be paid their expenses only on submission of an itemized statement.

Statements of receipts and expenditures for March for the Association committees and THE JOURNAL were approved.

Membership Report

Number of members April 12, 1947	3,337*
Number of members April 12, 1946	3,268
Gain over last year	69

* Includes 98 in military service (gratis)
171 honorary members

Number of members December 31, 1946	3,508

Treasurer's Office

On motion of Drs. Nafe and Portteus the treasurer was authorized to purchase a $5,000 United States Savings Bond with funds from the general fund of the association, and a $2,000 United States Savings Bond with medical defense funds.

1946 Annual Session, Indianapolis, October 29, 30, 31, 1946

Financial report of the local convention arrangements committee, showing a refund of $271.75 to the association, received from Dr. Gordon Batman, chairman of the committee. On motion of Drs. Nafe and Ellison, it was voted to send a letter of thanks to Dr. Batman over the names of the Executive Committee.

Legislative Matters

National

(1) On motion of Drs. Ellison and Portteus, the committee voted to purchase 200 booklets, entitled, "Blueprint for the Nationalization of Medicine," compiled by Marjorie Shearon, Ph.D., for distribution to the presidents and secretaries of the county medical societies and officers and councilors of the state association.

(2) Hearings on *S. B.* 545, commonly known as the Taft bill, are scheduled to start late in April.

(3) On motion of Drs. Nafe and Portteus, the Executive Committee approved paying the expenses of Dr. Norman Beatty, co-chairman of the Committee on Public Policy and Legislation, to Washington, D.C., to attend the legislative dinner being sponsored by the Indiana State Chamber of Commerce on April 28, if Dr. Beatty wishes to attend this meeting.

Veterans Affairs

Dr. Charles F. Thompson appeared before the committee and explained that the Veterans Administration had asked for a list of specialists in the counties of the state. On motion of Drs. Romberger and Portteus, it was decided to request each county medical society to supply such a list to the Veterans Committee.

Dr. Thompson also reported receipt of a new fee schedule from the Veterans Administration. On motion of Drs. Ellison and Portteus the committee went on record in favor of submitting this schedule to the county medical societies with the recommendation that it be accepted.

Dr. Thompson was asked to present these matters to the Council of the association at its meeting on April 13.

Organization Matters

Allocation of $2,600 by Lions Club to I.U. Medical Center for x-ray equipment. The committee approved the expenditure of approximately $2,600 by the Trustees of 'Indiana Lions Cancer Control Fund' of Lions International for new x-ray equipment at the Indiana University Medical Center.

Delegates to the Indiana State Conference on Social Work. The president and the executive secretary of the association were named as delegates to the November 5 to 8, 1947, meeting of this organization.

Recognition of fifty years in practice of medicine. On motion of Drs. Nafe and Romberger, it was voted to give some recognition to members upon completion of fifty years in the practice of medicine. Decision as to just what the recognition shall consist of will be made later.

Questionnaire from Raymond Rich Associates was referred to the president for reply.

Postgraduate Study

The question of the association sponsoring a postgraduate course was deferred pending discussion of the subject with the chairman of the Instructional Course Committee.

Future Medical Meetings

The executive secretary was instructed to attend the Conference on the Cooperation of the Physician in the School Health and Physical Education Program, at Highland Park, Illinois, on October 16-18, 1947.

State Board of Medical Registration and Examination

Kaadt Diabetic Institute. The secretary read a letter from a detective in the St. Louis police department expressing thanks for information about Kaadt Diabetic Institute.

The Journal

Report on advertising:

Additions	$558.22
Decreases	473.00
Total increase in March	$ 85.22
Total increase for year	$ 36.41

Letter from C. E. Pauley and Company explaining it is unable to grant a request for reduction in printing costs of The Journal was read by the secretary.

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

April 4, 1947.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

Copy for the following "Hints on Health" columns were approved:

Week of April 28, 1947—"Bladder Control."
Week of May 5, 1947—"Baseball Finger."
Week of May 12, 1947—"Causes of 'Stroke'."
Week of May 19, 1947—"Mastoiditis."

Letter from publisher of The Lawrenceburg Press, thanking the association for sending him "Hints on Health," was read.

Announcement from the Michigan State Medical Society to the effect it was starting a health column for weekly newspapers entitled "Health News" was read.

Offer of recordings of six three-minute radio programs called "Tell Me, Doctor" for $12.00 for the week's supply, by the Michigan State Medical Society, was discussed and decision deferred until the next meeting.

Approval was given for distribution of a booklet entitled "Mother Goose Health Rhymes" at the Indiana State Fair in the event the Committee on State Fair decides it wishes to hand them out.

The secretary announced that the mailing list had been brought up to date with the addition of the names of 219 newspapers.

The question of recommending that the name of the Bureau of Publicity be changed in the by-laws to Bureau of Public Education was discussed and action postponed.

The need of literature on health subjects for distribution to high schools will be investigated and discussed at a future meeting.

BUREAU OF PUBLICITY

April 18, 1947.

Present: H. G. Hamer, M.D., chairman; Ray E. Smith, executive secretary.

Electrical transcriptions of "More Life for You," an American Medical Association health program

now being broadcast over WFBM, and a radio program, "Tell Me, Doctor," offered by the Michigan State Medical Society, were heard. The secretary was instructed to notify the Bureau of Health Education of the A.M.A. that its transcriptions are believed to be of inferior physical quality, and that the bureau believes best results would be obtained from programs which include music, such as the "Melody of Life" series. The bureau decided against use of the "Tell Me, Doctor" programs.

Letter from Detective Harry Walk, of St. Louis, thanking headquarters for sending him a folder on the Kaadt Diabetic Institute, issued by the Indianapolis Better Business Bureau, was read.

Letter from Indiana Division, Indiana State Library, acknowledging receipt of the minute book of the Eighth District Medical society, was read.

Copy for a news release entitled, "Wild Mushrooms Can Kill; Better Not Take Chances," for mailing to daily and weekly papers of the state, April 28, was approved.

Copy for "Hints on Health" columns was approved, as follows:

Week of May 26, 1947—"Birthmarks."

Week of June 2, 1947—"Early Hay Fever."

COUNCILOR DISTRICT MEETINGS

FIFTH COUNCILOR DISTRICT MEDICAL SOCIETY

Dr. Dick J. Steele, of Greencastle, was elected president of the Fifth District Medical Society, and Greencastle was selected as the place for the 1948 meeting, at the annual society meeting held in Terre Haute on May 2.

Other officers elected were Dr. Robert K. Webster, of Brazil, vice-president, and Dr. M. C. Topping, of Terre Haute, secretary. The Terre Haute Academy of Medicine, meeting jointly with the district society, named the following officers for 1947-48: Dr. Ivan Gilbert, president; Dr. Joseph G. S. Weber, first vice-president; Dr. H. T. Goodman, second vice-president, and Dr. Stuart R. Combs, secretary-treasurer.

Speakers at the meeting included Dr. Cleon A. Nafe, of Indianapolis, president-elect of the Indiana State Medical Association; Thomas A. Hendricks, secretary of the Council on Medical Services, American Medical Association; Ray E. Smith, executive secretary of the Indiana State Medical Association; Dr. Tinsley Harrison, of Dallas, Tex., and Dr. Peter Rosi, of Chicago.

Dr. A. M. Mitchell, of Terre Haute, is councilor of the district which includes Vigo, Vermillion, Parke, Clay and Putnam counties.

SIXTH COUNCILOR DISTRICT MEDICAL SOCIETY

The Shelby County Medical Society will serve as host to the Sixth District Medical Society at Shelbyville in 1948, the date to be decided later. The invitation was extended to the district society at its 1947 meeting in Richmond on May eighth.

The program on May eighth included the following: "The Year in Medicine," by Dr. W. U. Kennedy of New Castle, councilor of the district; "Modern Trend in Treatment and Management of Syphilis," by Dr. H. Jerry Lavender, of the University of Cincinnati College of Medicine; "The Treatment of Common Cervical Lesions," by Dr. Carl P. Huber, of the Indiana University School of Medicine; "Diagnosis and Treatment of the Anemias," by Dr. Russell L. Haden, of the Cleveland Clinic; "An Evaluation of the Conservative and Surgical Treatment of Protrusion of the Intervertebral Disc," by Dr. George J. Garceau, of Indianapolis; "Your State Medical Association," by Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, and "The 1947 State Legislature," by Ray E. Smith, executive secretary of the association.

Officers of the district, whose terms expire next year, are Dr. Will Thompson, of Liberty, president; Dr. Clifford E. Canaday, of New Castle, vice-president, and Dr. Robert W. Kuhn, of Wilkinson, secretary-treasurer.

TWELFTH COUNCILOR DISTRICT MEDICAL SOCIETY

Three members of the faculty of the University of Cincinnati College of Medicine provided the scientific program for the annual meeting of the Twelfth District Medical Society at Fort Wayne on May sixth.

The speakers and their subjects were: Dr. A. Ashley Weech, professor of pediatrics, "The Emotional Needs of the Child in the Development of Behavior"; Dr. Edward McGrath, assistant professor of surgery, "Diagnosis and Management of Lung Tumor"; and Dr. Richard Bryant, assistant professor of obstetrics, "Toxemia of Pregnancy."

Other speakers were Dr. Floyd T. Romberger of Lafayette, president of the Indiana State Medical Association, and Ray E. Smith of Indianapolis, executive secretary of the association.

The following officers were elected: Dr. G. T. Bowers of Fort Wayne, president; Dr. Justin R. Nash of Albion, vice-president; and Dr. Karl M. Beierlein of Fort Wayne, secretary-treasurer. Dr. Paul A. Garber of South Whitley, councilor, presided.

LOCAL SOCIETY REPORTS

Delaware-Blackford County Medical Society members joined the Deleware County Society for Crippled Children and Adults on March eighteenth, in sponsoring a lecture and demonstration on "The Rehabilitation of the Physically Handicapped Veteran," by Dr. Donald A. Covalt, Medical Director for Rehabilitation, Veterans Administration, Washington, D. C.

Fort Wayne (Allen County) Medical Society members held a meeting on April fifteenth, in Fort Wayne. The guest speaker was Dr. Chester H. Warfield, of Fort Wayne, whose subject was "X-ray Aspects of Peptic Ulcer." Sixty-one members and guests attended the meeting.

Floyd County Medical Society members held a dinner meeting on April eleventh, in New Albany. The speaker of the evening was Dr. William F. Edwards, of New Albany, whose subject was "Headaches of Otolaryngolic Origin." There were twenty-one members present.

Fountain-Warren County Medical Society members met on April tenth, in Kingman. The speakers were Mr. Robert Rogers and Dr. Martha O'Malley, representatives from the State Board of Health. A discussion was also held regarding the needs of a proposed county hospital at Veedersburg. Ten members and twelve guests were in attendance.

Greene County Medical Society members held a dinner and business meeting on April seventeenth, at the Freeman Greene County Hospital, in Linton. The fourteen members present heard Dr. M. S. Mount, of Bloomfield, discuss "Empyema."

Hendricks County Medical Society members held a luncheon-business meeting on April thirteenth, in Brownsburg. Reports were given on a recent conference with the Hendricks County commissioners regarding the construction of a county hospital. This meeting was attended by ten physicians, their wives, and guests.

Parke-Vermillion County Medical Society members met on April sixteenth, at the Vermillion County Hospital, in Clinton. Nine members attended the meeting.

Vigo County Medical Society members met at Terre Haute, on April eighth. The speaker for this meeting was Dr. W. Donald Close, of Indianapolis, whose subject was "Recent Advances in Cardiac Therapy."

Vanderburgh County Medical Society members held a dinner meeting at the McCurdy Hotel, in Evansville, on April eighth. The sixty-four members present heard Dr. Samuel A. Overstreet, of Louisville, discuss "Medical Management of Peptic Ulcer."

Wabash County Medical Society members met at the Wabash Country Club, in Wabash, on April second. Dr. Charles J. Cooney, of Fort Wayne, spoke on tumors of the kidney and bladder. Nineteen members and guests attended the meeting.

Wayne-Union County Medical Society members held a dinner meeting at the Reid Memorial Hospital, in Richmond, on March twentieth. The meeting was addressed by Dr. Howard D. Fabing, of Cincinnati, whose subject was "Experiences With Concussion Syndrome." Twenty-three members were present.

The members met on April seventeenth at the Reid Memorial Hospital, in Richmond to hear Dr. William A. Altemeier, of Cincinnati, discuss "Treatment of Surgical Infections." Twenty-one members were in attendance.

Wells County Medical Society members met at the Caylor-Nickel Clinic, in Bluffton, on February seventeenth. Dr. Thomas O. Dorrance, of Bluffton, spoke on "Rh Factors in Blood Incompatibility." Fifteen members were present.

The members met on April twenty-first at the Caylor-Nickel Clinic, in Bluffton. The guest speaker was Dr. Raymond Fagan, veterinary epidemiologist, State Board of Health, whose subject was "Brucellosis." The meeting was attended by fourteen members.

WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

The third annual meeting of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association was held at the Columbia Club, in Indianapolis, April 23, 1947, with Mrs. Samuel J. Petronella presiding. Seventy-six officers and delegates attended the luncheon and business session.

Mrs. Jesse D. Hamer, Phoenix, Arizona, national president of the Woman's Auxiliary to the American Medical Association, was the guest of honor at a reception and dinner the preceding evening at the Indianapolis Athletic Club. A board meeting followed the dinner.

Speaking before the house of delegates, Mrs. Hamer stressed the importance of participation in all health educational activities. "Our organizations promote the prepayment medical care plans in all the states," she said, "and now that our work in aiding recruitment of nurse cadets is ended, we are taking great interest in the problem of shortage of nurses and are aiding in the nurse recruitment program."

Mrs. Hamer announced that the national organization will celebrate its 25th anniversary June 9-13 at Atlantic City, which also marks the 100th anniversary of the American Medical Association. The auxiliary now has 44 units organized.

Mrs. A. W. Ratcliffe, Evansville, was installed as president of the auxiliary and the following officers were elected for one year:

Mrs. William Morrison, Kokomo, president-elect.

Mrs. Charles Viney, Logansport, first vice-president.

Mrs. M. J. Thornton, South Bend, second vice-president.

Mrs. Leon Blum, Terre Haute, third vice-president.

Mrs. James W. Baxter, New Albany, fourth vice-president.

Mrs. Truman Caylor, Bluffton, recording secretary.

Mrs. J. W. MacDonald, Evansville, corresponding secretary.

Mrs. Wendell Kelly, Anderson, treasurer.

Mrs. Ratcliffe announced the following chairmen of standing committees:

Organization—Mrs. W. R. Morrison, 413 Conradt St., Kokomo.

Public Relations—Mrs. B. W. Harris, 1020 W. 5th Avenue, Gary.

Legislation—Mrs. Lester Smith, 238 Hume Mansur Building, Indianapolis.

Program—Mrs. D. E. Lybrook, R. R. 2, Galveston.

Hygeia—Mrs. C. O. Richey, 400 S. Kelsay, Evansville.

Bulletin—Mrs. Milton Gevirtz, 6528 Forest Avenue, Hammond.

Archives—Mrs. F. S. Cuthbert, 1027 W. Walnut St., Kokomo.

Finance—Mrs. Charles Wise, Camden.

Press and Publicity—Mrs. F. M. Gastineau, 5344 N. Pennsylvania St., Indianapolis; Mrs. J. S. Browning, 5880 N. Delaware St., Indianapolis; Mrs. Lymon Eaton, 291 E. Monroe St., Franklin.

Historian—Mrs. C. D. Ehrman, 119 S. 5th St., Rockport.

Parliamentarian—Mrs. Charles F. Voyles, 4150 N. Meridian St., Indianapolis.

Councilor—Mrs. S. J. Petronella, 4308 Baring St., East Chicago.

REPORTS OF OFFICERS AND COMMITTEES*

PRESIDENT

Mrs. Samuel J. Petronella

To give this report to the assembled body at the Third Annual Meeting of the House of Delegates is a distinct honor and privilege.

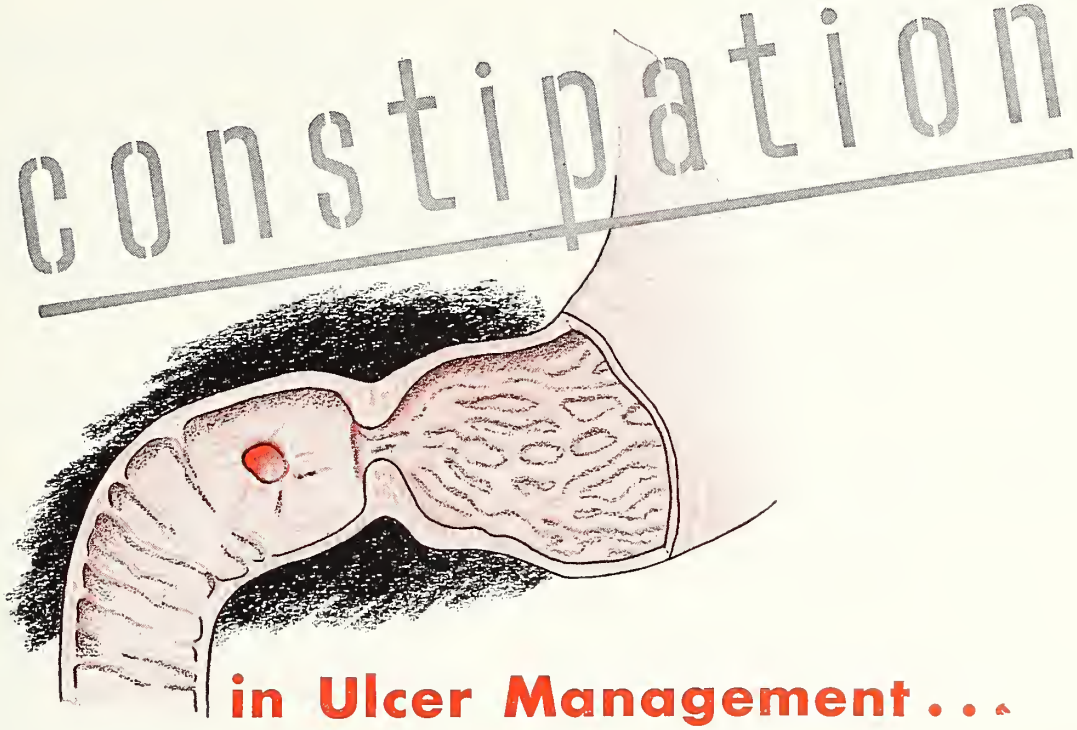
In summing up the years' work, one must look back to the starting point, which reminds me of the often-quoted Chinese proverb, "A journey of a million miles begins with a single step." A year ago the end of the journey seemed a long way off, but today I find the time has been far too short to accomplish the many things which might have been achieved.

It has been a pleasure to work hand-in-hand with the officers, chairmen, and county presidents. I am happy to have this opportunity to thank them, one and all, for their cooperation, and to express my appreciation for valued services, so loyally rendered. Without their help and consideration, our Auxiliary could not lay claims to progress and success in the past year.

Literature for study and reference have been sent to all counties throughout the year, and every phase of work suggested by our National Auxiliary has been highly recommended. To elaborate further upon this subject would be to encroach upon the reports of the chairmen and county presidents. However, I must say, with pride, we have had a year of renewed interest in all auxiliary projects,

* Presented before the House of Delegates Meeting of the Woman's Auxiliary to the Indiana State Medical Association, at Indianapolis, on April 23, 1947.

constipation



in Ulcer Management . . .

"Constipatian is nat an impartant **symptom** of ulcer, but is often the autstanding **complaint.** Many patients either disregard the 'indigestian,' distress ar pain . . . Such patients frequently become established cathartic addicts, with resultant bowel dysfunctian and abdominal discomfort ta canfuse the distress picture."

—Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 199.

Without disturbing the healing process or precipitating complications, "smoothage," as provided by Metamucil, initiates bowel evacuation by promoting reflex peristalsis through gentle distention.

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and the enthusiastic support of the auxiliary to these projects has culminated in a successful year.

This has truly been a fruitful year in organization. We have gained three hundred and eight new members, and now have twenty-five county auxiliaries. Adams County has been reorganized, and the counties of Morgan, Perry, and Kosciusko are in the immediate process of organization.

Your president attended the twenty-third annual meeting of the Woman's Auxiliary of The American Medical Association in San Francisco, July 1 to 4, 1946. Because this report was read at the state convention in November, and because it is contained in the April issue of the *Indiana State Medical Journal*, I beg leave to include it in my report for the files, but not to reread it in this report.

The next milestone was the annual state convention in Indianapolis, October 29 and 30. The board meeting and general meetings were well and enthusiastically supported. An innovation was the first meeting honoring our members-at-large. The attendance was the greatest in the history of the Indiana State Medical Association and the auxiliary registration of three hundred and fifty-five played a large part in making this possible. Our registration inspired the following remark, which I quote from the convention notes of the December issue of THE JOURNAL. "Someone was unkind enough to suggest that the auxiliary have its own convention, since the increase of registration of the women exceeded that of the men." I hope the attendance at French Lick this fall will even exceed this record.

It was of great interest and very instructive to attend the Third Annual Conference of State Presidents and Presidents-elect in Chicago, December 11 and 12, 1946. The conference was called to order by the president, Mrs. Jesse D. Hamer, and Mrs. Eustace A. Allen, president-elect, was presented as chairman of the conference.

On roll call by the constitutional secretary, the following were recorded present: Thirty-one state presidents, twenty-four state presidents-elect, eight chairmen of standing committees, twelve officers and directors, and three national past presidents.

Mrs. Hamer, president, read a report of her activities from July 4 to December 10, 1946, which was accepted with grateful appreciation. Her duties have been many and strenuous, and have taken her thousands of miles, visiting State Auxiliaries. Mrs. Hamer reported that The American Medical Association, through its Board of Trustees, is giving greater recognition to the Woman's Auxiliary at this time than it ever has in the past. The first joint meeting of the Board of Trustees and the Board of Directors of the Woman's Auxiliary was held in Chicago, December 10, 1946. Henceforth, the Board of Trustees will formulate definite plans for the activities of the auxiliary.

Doctor Fitzgibbions, of Oregon, addressed the conference on the importance of auxiliary work, and spoke of the importance of close relationship between auxiliary and medical society.

Guest speakers at the conference were Dr. James Miller, Dr. W. W. Bauer, Dr. Morris Fishbein, Dr. H. H. Shoulders, president, American Medical Association, Dr. Clifford Grulee, and Dr. Rollo K. Packard. The texts of these inspirational and instructive talks are contained in the last two issues of *The Bulletin*.

The reports of the state presidents and presidents-elect were stimulating and of great interest. They are also contained in the December issue of *The Bulletin*. The following resolution was adopted:

That the national officers and chairmen include the presidents-elect on their mailing list.

This resolution was presented by the State of Indiana with the intent of aiding all states. The following recommendations were adopted:

1. That state and county auxiliaries sponsor only such speakers as are recommended by the American Medical Association, and state and county medical societies.
2. That because of the many requests for information concerning auxiliary activities made by state presidents, during this conference, and because much of the information desired has already been published in *The Bulletin*, the official publication of the Woman's Auxiliary, and much information needed by auxiliary workers will continue to be published in *The Bulletin*, in accordance with the established policy, it was therefore recommended that state presidents make known to the officers, committee chairmen, and other working members of their respective state auxiliaries, the above facts concerning *The Bulletin of the Woman's Auxiliary*.
3. That public relations programs not be termed as such.

The keynote of all discussions during the conference was the importance of the County Auxiliary, whether large or small, in membership.

In January your president was invited to address the Secretaries Conference of the state medical association in Indianapolis. "Auxiliary Plans," was the topic, and on behalf of the auxiliary I was very honored and pleased at this recognition from our state medical association. The text of this address was published in February in the state journal. Following this meeting, letters were sent to each medical secretary whose county had no auxiliary, asking for a representative from their county. The response was most favorable.

One of the most pleasant and arduous duties was the personal correspondence carried on during the year. Besides announcements sent by the recording secretary, and packets of study material, three hundred and fifty personal letters were written. A report of the state auxiliary was also sent to the national historian for approval, and two copies to Miss Wolfe, the executive secretary, for filing. Because of the early date this report was requested, it was impossible to summarize adequately the years' work in its entirety.

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The following county auxiliaries were visited: Allen, Cass, Carroll, Clark, Floyd, Fulton, Hancock, Howard, Vigo, Vanderburgh, Sullivan, Porter, Madison, Marion, Marshall, and Wells. An invitation to Delaware-Blackford County was declined because of illness. I wish to acknowledge here the support and many kindnesses extended me from my own county auxiliary and medical society.

I have twice been a guest of the Illinois Auxiliary, and on May 6 and 7 I will be a guest of the Ohio Auxiliary. It will also be an honor for me to serve on the Election Committee at the national convention in June.

My last service in this capacity will be the privilege of reading the report for Indiana at the national convention. It seems expedient to note here that state presidents will be called upon to report briefly, not exceeding two minutes, any auxiliary accomplishment.

To the members of the county auxiliaries who have been so gracious and hospitable, and to all members of the Woman's Auxiliary to the Indiana State Medical Association, I give my sincere thanks and gratitude for the privilege of serving you and working with you this year.

FIRST VICE-PRESIDENT

Mrs. C. E. Munk

The reports of the officers of the state auxiliary are given at the annual meeting in order that members may know how the auxiliary, as an organization, stands and what it has accomplished during the year.

Our state is divided into four districts for organization purposes. The four vice-presidents are in charge of the following districts:

District No. I—N. E. Section, Mrs. C. E. Munk.

District No. II—N. W. Section, Mrs. Charles Wise.

District No. III—S. W. Section, Mrs. Clifford O. Richey.

District No. IV—S. E. Section, Mrs. Morton Wolfe.

This year we have added two county units to our state auxiliary. Fulton County, in District No. II, was organized with twelve charter members in September by Mrs. Petronella. Adams County, in District No. I, was re-organized in November with twelve members.

Three counties, Perry, Morgan and Kosciusko, are in various stages of organization. We are sorry not to be able to complete their organization this year but hope to see them included in our membership in 1948.

Your chairman sent sample organization letters and material to each vice-president, with instructions to contact the secretary of the medical society in unorganized counties in regard to forming an auxiliary. This was done in my district, where there were ten unorganized counties. As a result, one county (Adams) re-organized, and Kosciusko County is in the process of organization.

This year has seen a decrease of twenty members-at-large. A number of these have become associate members of county units. Letters were sent to county presidents urging them to invite members-at-large residing in their vicinities to attend some of their meetings. Members-at-large received letters and copies of the paper read by Dr. W. U. Kennedy at the last meeting of the House of Delegates; the paper of Dr. N. K. Forster read at the fall luncheon; "Blueprint for the Nationalization of Medicine," by Marjorie Shearon; and *The Ounce of Prevention*, the Health Bulletin of Lake County.

Two maps and reports, one in November, and the other in April, were sent to the national organization chairman to show the growth of our state auxiliary. These maps, with the maps of other states, are to be on display at the national auxiliary meeting to be held in Atlantic City in June.

I believe you will be interested in a few statistics. In Indiana we have:

County Medical Societies, 82; membership, 3,450.

County Auxiliaries, 25; membership, 1,300.

(Thirty-seven and one-half per cent of the doctors' wives are auxiliary members.)

State Auxiliary membership in 1946, 1,019.

State Auxiliary membership in 1947, 1,300 (an increase of 281).

The national auxiliary has forty-three component state auxiliaries. In 1945 Indiana ranked tenth in number of members. In 1946 we were in eighth place. With our additional two hundred and eighty-one members for 1947, it is to be hoped that we will better our position or at least hold our own.

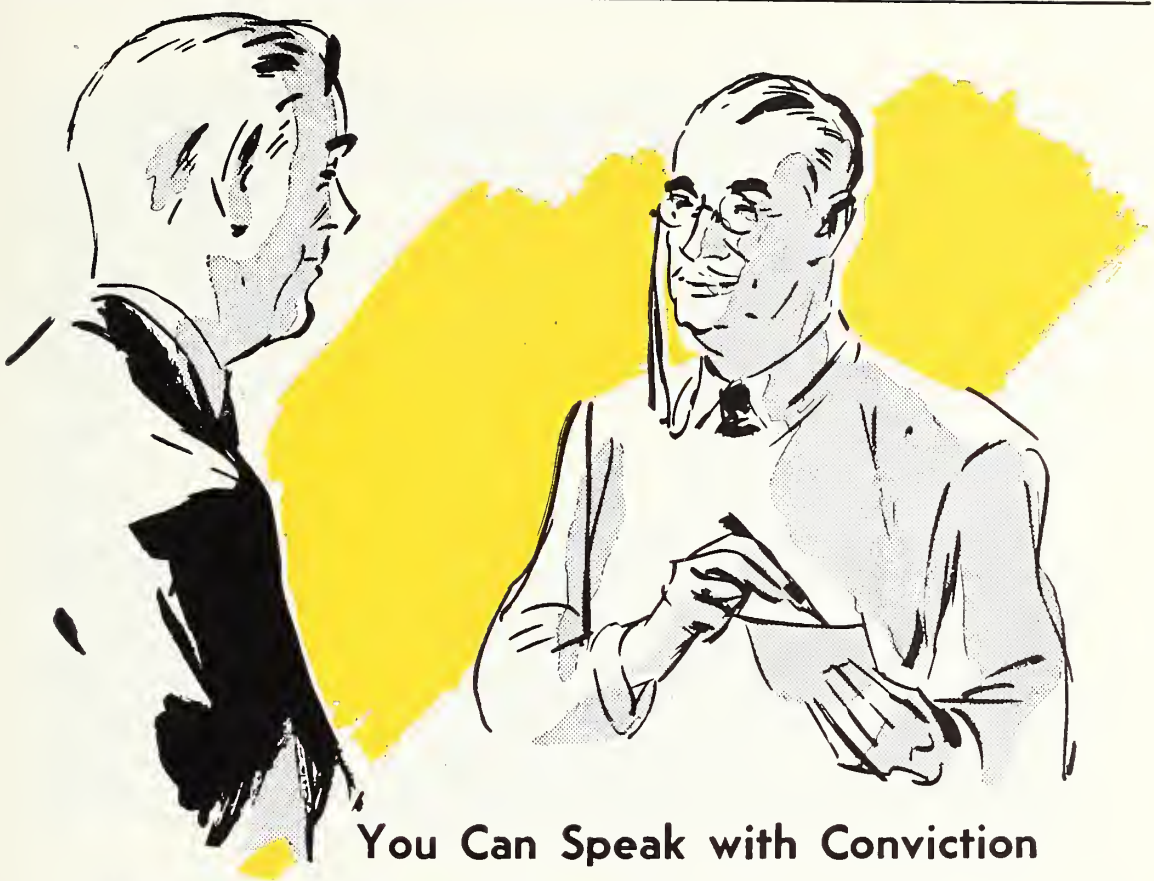
I wish to thank the organization committee for their splendid cooperation. It has been a real privilege to have served with our gracious president, Mrs. Samuel J. Petronella. Her cooperation and interest in organization has been heartening.

SECOND VICE-PRESIDENT

Mrs. C. L. Wise

Well-organized plans were received from the first vice-president concerning organization. Letters had been sent out by the state president to the county medical society secretaries of counties with no organized auxiliaries, asking permission to organize their counties. Results—no answers.

Final correspondence with Mrs. Marcia Huckleberry, of Danville, in Hendricks County, who was interested in county organization, reports that progress has been hindered due to the lack of interest of other ladies in the county.



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I mailed to all members-at-large Doctor Kennedy's talk before the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association, and Doctor Forster's speech at the auxiliary luncheon at Indianapolis in October.

Fulton County was organized during the year. A membership file was presented to me with a membership of twenty-nine members in 1945, with seventeen members having responded as members for 1946. I contacted those who had not responded and secured four more, bringing the 1946 membership up to twenty-one. One more member had joined an organized county. Fifteen of the 1946 members responded to my appeal to continue as members-at-large for 1947. Receipts for dues were sent to each member.

PROGRAM

Mrs. D. E. Lybrook

A program including legislative, educational, friendly relations, and social activities, as approved by the Advisory Committee of the Indiana State Medical Association and accepted by the state auxiliary president, was sent to each of twenty-four auxiliary units in Indiana in August, 1946. In October a report was given at the time of the state medical meeting. This report included an explanation of program material and a challenge to meet the suggestions as given by Mrs. Garnjbost, national program chairman.

In January literature on broadcasting of "Doctors—Then and Now" was sent to county presidents as requested by the Bureau of Health Education of the A.M.A. In February cards were sent to the county auxiliary presidents requesting a classified list of 1946-1947 meetings. The response to these cards was most satisfactory. Eighty-three per cent of the counties answered. The average for the twenty counties was 1 legislative meeting, 1.5 friendly relations meetings, 2 educational meetings, and 3 social meetings.

The common effort of the medical profession is to defeat legislation of government control of medicine. The auxiliary has aided in this effort through their legislative program. The educational program presented by radio programs, work of the auxiliary with health groups, hospital groups, parent-teacher groups, has resulted in outstanding programs during the year. The social programs permeate the activity of the other three classifications. In some it is of utmost importance in building a new group and keeping interest among a different age group.

The appreciation of the Indiana State Medical Association and the confidence they place in the auxiliaries builds a greater desire to work for a still more constructive program. May 1947-1948 be an even greater year.

PRESS AND PUBLICITY

Mrs. Otto H. Bakemeier

This committee wishes to thank the county presidents and publicity chairmen for their cooperation during the past year. Every month county reports and items of interest to the auxiliary were published in THE JOURNAL, one hundred ten items covering eighteen of the twenty-four counties.

Resumés of the business of all board meetings were printed. The annual reports of all county presidents and committee chairmen were compiled for publication. Local newspapers were contacted for all state meetings.

Letters were sent to all county presidents and publicity chairmen requesting publicity for THE JOURNAL and, I wish to publicly thank Mrs. Carbone of Lake, Mrs. Vore of Marshall, Mrs. Seipel of Porter, Mrs. Caylor of Wells, Mrs. Nelson of St. Joseph, Mrs. Wyatt of Allen County, and the Central Clipping Service for excellent cooperation.

In closing, may we request that continued cooperation be given the newly-appointed chairman, and may we remind you that the duty of this committee is to serve each auxiliary in any way possible. Thank you.

BULLETIN

Mrs. Milton Gevirtz

Bulletin subscriptions received at central office from June 1, 1946, to February 1, 1947, inclusive—115 subscriptions, which is an increase of 23.

POSTWAR PLANNING

Mrs. C. W. Dahling

Under the educational activities of the Postwar Planning Committee to the Indiana State Medical Auxiliary, twenty-three letters were sent to the various county auxiliaries, urging them to make a study of prepayment medical plans in the state of Indiana. Literature from the national auxiliary and a reprint of the article entitled "Taft Maps Offensive Against Nationalized Medicine," were also mailed to county auxiliaries for study.

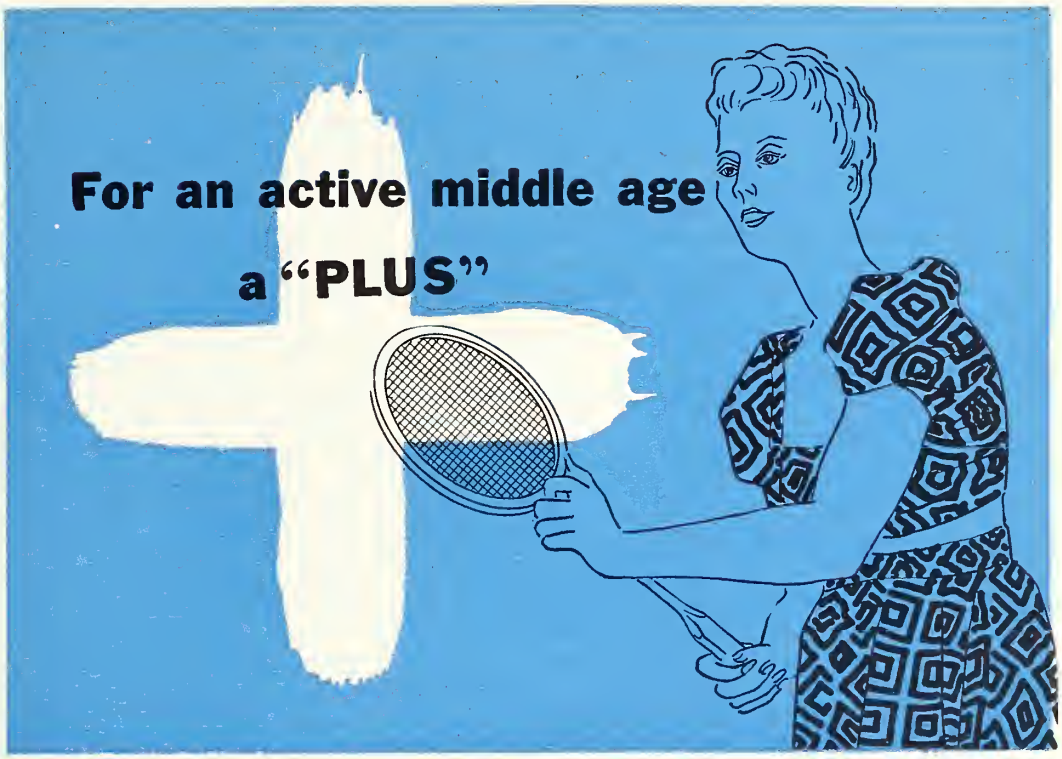
ANNUAL REPORTS FROM COUNTY AUXILIARIES

ALLEN COUNTY

Mrs. Lawerence Shinabery, President

Allen County has 129 paid members.

Eight meetings were scheduled for the year. One membership tea; two joint social meetings with the medical society; three educational meet-



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"Premarin" provides effective estrogenic therapy through the oral route with comparative freedom from untoward side effects.

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Tablets of 2.5 mg.....bottles of 20 and 100.
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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water-soluble sulfates. The water solubility of conjugated estrogens (equine) assures rapid absorption from the gastrointestinal tract.

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ings (one of which pertained to legislation and welfare); one bridge party, and the May meeting, at which election of officers is conducted.

The health education program for teen-age girls proved so successful the past year that those in charge of the recreation centers requested that it be presented again. With little change in the original procedure, the program "Health for Glamour" was again presented at the Jefferson Recreation Center. This same series of five lessons was then taken to McCullock Center, where those in attendance were 100 per cent Negroes. Climaxing the lessons was a style show, with the daughters of doctors modeling. Auxiliary members prepared and gave the talks to the girls.

The drive for sample drugs is now being conducted by members of the Postwar Planning Committee and the Liaison Committee.

The report of the Hygeia Chairman is incomplete, inasmuch as it does not include the subscriptions submitted directly to the national office. We are awaiting this information. The report to date is: twenty-one one-year; two two-year; seven three-year subscriptions. Gift subscriptions by the auxiliary went to eleven center libraries in the city. Four *Bulletin* subscriptions are reported, but this does not include direct subscriptions.

Articles on current medical legislation, both state and federal, have appeared monthly in the *Caduceus*, organ of the Allen County Medical Society, Academy of Medicine and Surgery, and Isaac Knapp District Dental Society. These articles appear under the caption, "Allen County Medical Auxiliary," and are prepared by the chairman of Press and Publicity.

Eight executive board meetings have been held, with still another on our calendar. There has been one executive committee meeting.

CARROLL COUNTY

Mrs. Max R. Adams, President

Carroll County Auxiliary sends greetings to the Indiana State Medical Auxiliary.

Our auxiliary this year consists of seven members, five who are active. With so few in number we cannot carry on the regular work, or have programs, except personally through our different clubs. Two of our members conducted a program on "Medical Rehabilitation" in one of our literary clubs this year.

We have an excellent *Hygeia* Chairman. She reports seven two-year and two one-year subscriptions. We are very proud of one of our members, Mrs. Wise, who is one of our state vice-presidents.

As a group, we have had eight dinner meetings with our husbands. We "sit in" on all of their meetings and are trying to back them up 100 per cent.

CASS COUNTY

Mrs. W. W. Holmes, President

During 1946 there were twenty-five paid memberships.

We had eight gifts of *Hygeia* to schools and forty subscriptions from doctors and dentists.

On the third Friday of each month the auxiliary joined the Cass County Medical Society for dinner at the hospital. After the dinner the group separated for their respective business meetings. At three meetings the ladies were invited to hear the speaker for the doctors. The ladies had two guest speakers of their own. Doctor Miller, from Longcliff, talked of her twenty years' experiences in China. Miss Knapp, superintendent of Cass County Hospital, told of her experiences under the Red Cross in Asia Minor.

Two business meetings were followed by a social hour. Mrs. Viney brought back enlightening reports from the San Francisco convention and also from the state meetings.

In February an afternoon tea was given in honor of our state president, Mrs. Petronella. Other guests were ladies from Kokomo and Carroll county.

New officers were elected at the regular February meeting: Mrs. W. W. Holmes, president; Mrs. Earle Bailey, vice-president; Mrs. Bryce Fitzgerald, secretary-treasurer.

On April 11 Dr. Fishbein was a dinner guest. The auxiliary sponsored his public lecture on cancer in the high school auditorium. The auxiliary gave $25.00 to the local cancer fund.

CLARK COUNTY

Mrs. Mier Bizer, President

Eleven active members.

The auxiliary to the Clark County Medical Society held five luncheon-business meetings and four educational meetings, the speakers including:

1. The tuberculosis nurse of the county—speaking on the duties of her office.

2. A nutritional field representative—speaking on the functions of the nutritional branch of the American Red Cross.

3. The county tuberculosis executive secretary—explaining the use of the mobile x-ray unit to be used in the county.

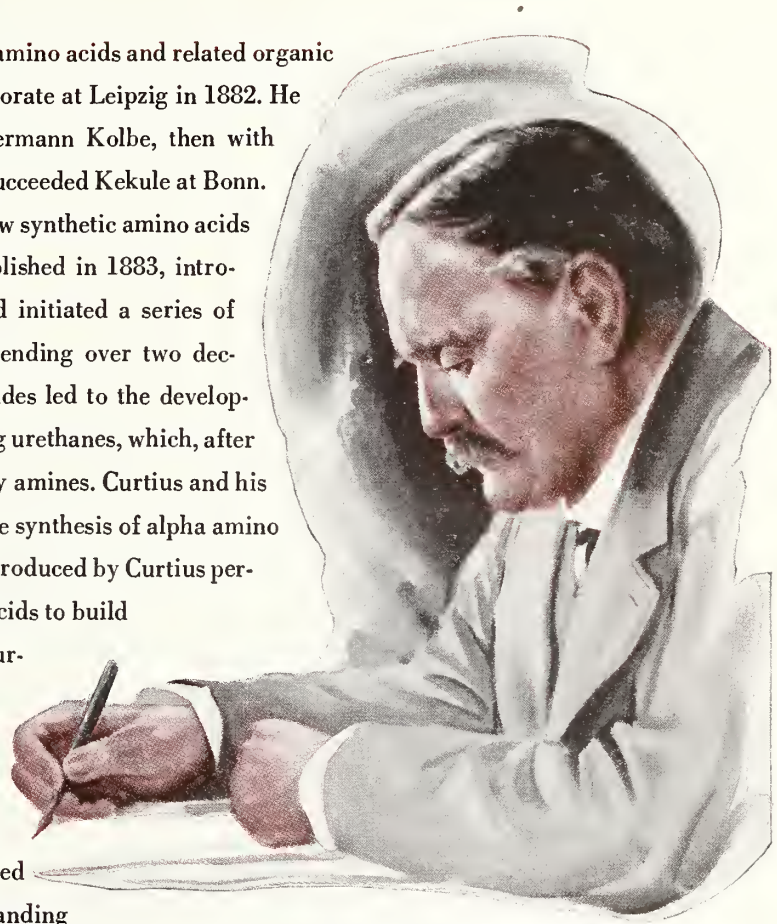
4. The superintendent of the local hospital—speaking on the needs of the hospital and the future organization of a hospital guild to be sponsored and organized by the auxiliary.

Two social meetings were held, one being for the purpose of a white elephant sale to earn funds; the second a Christmas party, at which six tables of bridge were entertained.

Two joint meetings were held with the Floyd County Auxiliary—one in honor of Mrs. Petronella,

Men and Amino Acids

This eminent investigator of amino acids and related organic compounds obtained his doctorate at Leipzig in 1882. He was associated first with Hermann Kolbe, then with Adolph Baeyer; in 1896 he succeeded Kekule at Bonn. His dissertation on several new synthetic amino acids related to hippuric acid, published in 1883, introduced diazoacetic esters, and initiated a series of systematic investigations extending over two decades. His work with acid azides led to the development of a method of preparing urethanes, which, after acid hydrolysis, yield primary amines. Curtius and his pupils evolved methods for the synthesis of alpha amino acids. Acid azide reactions introduced by Curtius permitted the linkage of amino acids to build polypeptides. As a teacher, Curtius attracted students from many countries. His elucidation of numerous problems associated with the chemistry of amino acids pointed the way to a clearer understanding of proteins and protein derivatives and their role in nutritional science.



THEODOR CURTIUS—1857-1928

The Arlington Chemical Company

Yonkers 1, Arlington *New York*

Fifth in a series

state auxiliary president; the other to hear Dr. Williams, head of state mental health.

A baby health contest was sponsored by the Auxiliary at a city-wide Community Day, to further interest in infant health.

Auxiliary members and their husbands chaperoned a mixer dance at the local high school.

Each month of the year, a member was supplied as a volunteer worker at the County Tuberculosis Clinic.

DELAWARE-BLACKFORD COUNTY

Mrs. W. J. Quick, President

Our auxiliary has an eligible membership of seventy-five, and a paid membership of fifty. Monthly meetings have been held since October, 1946, with an average attendance of thirty.

Our project for the year has been aid to the Harry Mock School for Crippled Children. This project has stimulated much interest within our group, and has been very successful, both materially and financially, for the school. At Christmas we gave books, games, selected toys, records, a doll and bed, and a decorated tree. A cash contribution of $85 was donated, of which $51 was realized at a "White Elephant" sale, conducted at our February meeting. We have completed fifteen scrapbooks for the children, which were designed and supervised by an artist member and her committee.

Our project was introduced at the first meeting of the year, in October, when Miss Josephine Clevenger, president of the Mock School, spoke to us, following a dinner. She discussed the work and the needs of the crippled children. We began making scrapbooks for the school at our November meeting.

In December the auxiliary and members of the medical society were dinner guests of Miss Nellie G. Brown, Superintendent of Ball Memorial Hospital. A social hour followed during which time we prepared and wrapped our gifts for the children of the Mock School.

In January we again worked on the scrapbooks. In February we were entertained at a pot-luck dinner, and our "White Elephant" sale was conducted.

In March, following a luncheon at Ball Hospital, we spent the afternoon sewing for the hospital. Mrs. D. E. Lybrook, state program chairman, was a guest and spoke to us at this meeting.

On April 15 we were entertained at an evening bridge party at the home of one of our members. New officers were elected at this meeting.

Our year's program will be concluded with a picnic in May, with the wives of interns and residents of Ball Hospital as our guests. At this meeting Mr. Ray E. Smith, executive secretary to the Indiana State Medical Association, will speak to us. He will explain the prepayment medical care insurance plan which is now in effect in our State.

FLOYD COUNTY

Mrs. Augustus P. Hauss, President

1. The auxiliary has revised the Constitution and By-Laws so the names of the newly-elected officers and chairmen of the standing committees for the coming year will be received by the state auxiliary at the beginning of the fiscal year.

2. The Woman's Auxiliary were guests at a dinner and entertainment given by the Floyd County Medical Society, in June.

3. A special luncheon meeting of the Clark and Floyd County Auxiliaries to meet the state president, Mrs. Petronella, was held in September.

4. Mrs. Herbert Sloan, chairman of the Program Committee, submitted the following:

October 11—Miss Primrose Hockey, English exchange teacher, spoke on maintaining adequate health during wartime rationing in England.

November 8—Mental Health in Indiana. Dr. Clifford Williams. The Clark County Auxiliary were our guests.

December 13—Christmas Musical Program. Mrs. William Burke gave the program.

January 10—Miss Elsa Strauswig, librarian, book review.

February 14—Legislation. Dr. A. P. Hauss spoke on legislation and medical economics.

March 14—Annual business meeting. Election of officers for the coming year. They are: President, Mrs. Harry Voyles; President-elect, Mrs. John Paris; Vice-president, Mrs. Irvin Streepey; Secretary, Mrs. Howard Byrn; Treasurer, Mrs. Herbert Sloan.

April 11—Talks by Senator William Bates and Representative Evan McLinn on legislation.

Standing Committee Reports

Public Relations: Mrs. James Baxter, Chairman, arranged for talks to Senior and Junior High School students on venereal diseases. A Public Health doctor spoke to the boys and a Registered Nurse to the girls.

The Auxiliary sponsored a four weeks' paid newspaper announcement of a national radio program—"Doctors Then and Now."

Hygeia: Mrs. William Garner and Mrs. Thomas Hewlett sold 31 subscriptions.

Bulletin: Mrs. James Y. McCullough sold 12 subscriptions.

Legislation: Letters were sent to Senator Bates and Representative McLinn pertaining to medical legislation.

Postwar Service: Mrs. Parvin Davis collected and sent about 310 pounds of drugs and instruments to the European Relief Organization.

Auxiliary Records: (1) Scrap-book, compiled by Mrs. A. M. Baker; (2) a card index system has been established for the auxiliary members; (3) a historian has been appointed by the auxiliary.

In the death of Mrs. Kenneth Brown, on January 10, 1947, we lost a loyal member. At the time of her death, she held the office of recording secretary.

We have thirty-five active members. I am pleased to report a year of activity and interest.

HANCOCK COUNTY

Mrs. M. B. Ferrell, President

New officers were installed at the February meeting. We have twelve paid members. The auxiliary met with the doctors at a joint dinner meeting once a month.

The auxiliary has four social meetings each year. We have sold six subscriptions of *Hygeia*. We are planning to do extensive work when we get the new County Hospital. We were guests of the Anderson Club for a dinner meeting and enjoyed Mrs. Petronella's visit with us.

HOWARD COUNTY

Mrs. R. E. McIndoo, President

The Woman's Auxiliary to the Howard County Medical Society submits the following report:

Our group consists of thirty-nine members, including one member-at-large, two affiliate, and five new members, which shows an increase of six members.

Mrs. Ruben Craig, program chairman, planned our year book. In it two meetings were given to social activities; one meeting was combined with the Howard County Medical Society; two were the following educational programs:

(a) Our first meeting, in October, was in honor of our state president, Mrs. Samuel J. Petronella, who gave us a very instructive talk on medical problems. Also, Mrs. D. E. Lybrook, state program chairman, and Mrs. F. S. Cuthbert, state historian, were present.

(b) *Hygeia* study was given by Mrs. Garvey Bowers, *Hygeia* chairman. She was instrumental in securing forty-one one-year subscriptions to the magazine, exceeding our quota. The auxiliary placed five one-year subscriptions in the city recreation centers and in the public schools.

Legislative study: Our legislative chairman, Mrs. Copeland Bowers, presented an interesting discussion of Marjorie Shearon's "Blue Print for Nationalization of Medicine."

Public Relations: In charge of Mrs. W. R. Morrison, chairman. Our efforts this year were concentrated on presenting the health insurance plan to the public. A series of radio talks, from April 7-11 were arranged by Miss Lucy Schuler, co-chairman. Dr. W. U. Kennedy, representative of Mutual Medical Insurance, Inc., with Mr. Edward C. Morris, Indiana representative of the Blue Cross, gave addresses on the two insurance plans April 10 at Memorial Hall, which was open to the public. All organizations, including the labor unions, were contacted; we were very pleased by the response. Before the meeting, Dr. Kennedy and Mr. Morris, with representatives of the U.A.W. and A.F. of L., participated in an open forum over the radio, discussing the different phases of the health plans.

The pamphlets, "Doctors Then and Now," which were sent by Mrs. Lybrook, were distributed and placed before the public. A donation of $15 was given to the Cancer Fund. The Howard County Medical Society asked the auxiliary to sponsor a program interesting high school graduates in nurse's training.

The auxiliary has followed, with the permission of the Advisory Council from the Howard County Medical Society, all requests and suggestions of the State Auxiliary as closely as possible. We feel that the year 1946-1947 has been a successful one.

LAKE COUNTY

Mrs. B. W. Harris, President

The Lake County Auxiliary is divided into three branches, namely: Gary South Branch, Hammond, and East Chicago-Whiting. The branches hold monthly meetings. County meetings are held in June, October, December, and April. There were five meetings of the Executive Board.

We have 100 members, a gain of 22 members; *Bulletin* subscriptions are 34, and 17 subscriptions were secured for *Hygeia*; 43 letters and telegrams were sent to national and state legislators concerning bills affecting medical practice; $25 was donated to cancer control; $75 was given to a worthy girl to assist her in her education as a nurse, (this is known as the Adelaide Shanklin Scholarship—Mrs. Shanklin was the first county president); 122 one-half pound boxes of candy and 7 strings of Christmas tree lights were donated to the United States Veterans Facility at Marion; 150 bags of cookies were donated to the Men's Shelter at Hammond; a phonograph and records were presented to St. Margaret's Hospital at Hammond for the children's lounge; 450 pounds of drugs and instruments were shipped to the Medical and Surgical Relief Committee of America; a "White Elephant" sale and raffles of baked goods were held to make money for contributions to local welfare drives.

Social meetings were: luncheons with cards, dinners, and style shows.

Educational meetings were: public relations, legislation, book reviews, and musicals.

Auxiliary members and the Lake County Medical Society were guests of the Inland Steel Company, for dinner and a tour of the plant, with spe-

cial attention to safety, the company's medical program, and facilities of the plant.

Officers for the ensuing year were elected and installed in April.

MADISON COUNTY

Mrs. F. C. Guthrie, President

Eight meetings were held for the year 1946-1947. Seven of the meetings followed joint dinners with the Medical Society. We have forty active members.

This has been a transition year from war to peace activities. We have been happy to welcome back the younger women, wives of doctors in service. Briefly, we have accomplished the following:

(1) The establishment of a fund for scholarship aid to a nurse at St. John's Hospital School of Nursing. This year the money was raised by a gift of $5.00 from each doctor's wife.

(2) The auxiliary continues to support and back the Victoria Guild, a larger organization aiding St. John's Hospital in various ways.

(3) At the time when the proposed so-called "Veteran's Chiropractic Bill," H.B. No. 174, was about to come up, we were able to secure the promise of our representative to work against it. Letters were also sent to all representatives on the Committee of Public Health. We are proud that Madison County helped to keep this bill in committee.

(4) Our *Hygeia* chairman secured thirty-three yearly subscriptions to *Hygeia*, five for three years, five for two, and eight for one year.

(5) Three of our meetings were social; one a Christmas dinner followed by a gift exchange; one featured a most interesting talk on the art of ceramics as applied to figurines, boxes and similar ornaments. The May meeting will be a get-together for ladies only.

(6) The highlight of the year was our April 21st meeting, attended also by several doctors and their wives from Hancock County. Mrs. Petronella was our guest speaker.

MARION COUNTY

Mrs. Emmett B. Lamb, President

Now that we have entered the postwar era, many of our doctors' wives have returned and have joined the Woman's Auxiliary to the Marion County Medical Society, with enthusiasm. We have 364 paid-up members—an increase of 146.

We began our year with preparations for the entertainment of the doctors' wives attending the annual state convention of the Indiana State Medical Society. Also, during the summer, the committee in charge of our special project collected 46 cartons (about 1,000 pounds) of sample drugs from the doctors and sent them to the Medical and Surgical Relief Committee of America, in New York. The Indianapolis Chapter of the Red Cross cooperated fully with us.

We have had four meetings and an open house tea, and will have our fifth on May 15. The first was a very successful musical tea honoring our returned service men's wives, and also our charter members, this being the occasion of our twentieth anniversary. Our own talented members furnished a delightful program. The second meeting was a luncheon-bridge, attended by one hundred eighty-three members. Mrs. Samuel Petronella was our special guest. She gave us important information concerning the work of the Auxiliary to the Indiana State Medical Society. Also, Dr. W. U. Kennedy's report, given to the House of Delegates meeting, in April, 1946, was read at this meeting.

In the latter part of February we had an interesting legislative meeting, consisting of a luncheon at the Hotel Lincoln, at which time Mr. Ray E. Smith told us about important medical legislation. Following this we visited the Senate, with Mr. Smith as guide. One hundred members were at the luncheon. On March 3 we held our annual guest tea in Block's auditorium, inviting members of important civic organizations and auxiliaries to various labor unions. The speaker was Mr. Paul Bourscheidt, Executive Director of the Illinois Hospital Association. He discussed Voluntary Medical Health Insurance plans as opposed to the government controlled variety. His subject was "Shall It Be Uncle Sam, M.D.?" There were about three hundred present.

On April 22 the members of the local auxiliary board held open house at the home of the president so that members of the Woman's Auxiliary to the Marion County Medical Society could meet Mrs. Jesse Hamer, president of the Woman's Auxiliary to the A.M.A., Mrs. Samuel Petronella, president, and Mrs. A. W. Ratcliffe, president-elect of the Woman's Auxiliary to the Indiana State Medical Society, who were in Indianapolis to attend the House of Delegates Meeting.

Our last meeting will be a business meeting at 11 A.M., on May 15, for election of officers, followed by a luncheon and bridge at noon at the Indianapolis Athletic Club. Since the first of the year we acted as hostesses one morning to the Hoosier Patrons Salon Exhibit in Block's Auditorium, we took over the doctor's task of soliciting the medical profession for the American Red Cross, which required quite an organization of solicitors, and collected $2,500 over our goal. We maintained a booth at L. S. Ayres & Co. for one week of the Cancer Control Drive.

There were five executive board meetings, the last one a luncheon at the Woodstock Country Club. Our telephone committee has been most active in calling all doctors' wives and auxiliary members on various occasions, and are now calling wives for an important meeting the doctors are having this month. We have permanent name cards that are pinned on each member at the meetings.

Reminding people to "See Your Doctor"

Parke, Davis & Company believes that people need to be constantly reminded of the value of prompt and proper medical care. Educational advertisements—like the latest one, reproduced below—appear regularly, in color, in LIFE and other national magazines. Audience: more than 22 million people!

Some things you should know about "stomach ulcers"

No. 204 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



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DURING recent years there has been a sharp increase in the incidence of ulcer of the stomach.

Some doctors report that within eight years ulcer cases have increased by as much as 100%.

Though the exact cause of stomach ulcer is still unknown, it has been observed most frequently among people subject to nervous tension and anxiety—about four times as frequently among men as among women.

Fortunately, doctors today have a number of effective methods of treatment at their command.

Improved drugs have been developed to relieve pain and hasten healing. With modern methods of treatment, fewer restrictions are placed on the ulcer patient. Under proper medical supervision, the ulcer patient today can generally lead a nearly normal life. Seldom nowadays do doctors find it necessary to prescribe as rigid a regimen as was formerly indicated.

Your doctor keeps in constant touch with the new developments in ulcer therapy. His own experience and his understanding of the individual patient enable him to choose the treatment best suited to each case.

Stomach ulcers seldom develop without warning. A common symptom is stomach pain several hours after meals, or during the night. But any regularly recurring abdominal pain should be considered a signal that something may be wrong. And your best chance to escape serious trouble and lengthy illness lies in getting medical attention immediately.

SEE YOUR DOCTOR! If you have frequent stomach pains or "indigestion," don't dose yourself. You may get temporary relief from your symptoms, but the medication you use may actually make your ailment worse. See your doctor and let him decide the cause of your trouble. He alone is qualified to diagnose your case and recommend treatment. Ask his help at the first sign of something wrong.

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories • Detroit 32, Mich.

We have ninety-four *Hygeia* subscriptions. In addition to sending subscriptions as gifts to various civic groups, such as the Y.W.C.A., et cetera, we sent subscriptions to all the high schools in Marion County. We have only six subscriptions to the *Bulletin*, although several others subscribe direct.

Our press and publicity secretary has had splendid publicity for us in all three newspapers in the city for each meeting. Throughout the year we have had splendid cooperation from Mr. Joseph Palmer, executive secretary to the Indianapolis Medical Society, from Mr. Ray E. Smith, executive secretary of the Indiana State Medical Society, and from the medical society itself.

It grieves us to report the death of three of our members: Mrs. Roy Geider, Mrs. Jack Pilcher, and Mrs. Raymond Beeler.

MARSHALL COUNTY

Mrs. M. O. Klingler, President

Number of members—fifteen. Number of subscriptions to *The Bulletin*—eight.

Place of meeting usually is in Plymouth. We meet nine times each year. Four of our members attended the State Meeting. At the meetings we always discuss medical current events. One meeting was a report of the state meeting; one meeting a talk on "What Women Want"; another meeting a talk on "Personality."

The December meeting was a Christmas party at the home of Mrs. C. R. Graham in Bourbon. The March meeting was a luncheon at the Maxinkuckee Inn in Culver, with Mrs. Donald Reed as hostess. Our state president, Mrs. Petronella, and the Fulton County Auxiliary were our guests.

Our April meeting was a luncheon at the home of Mrs. C. G. Mackey of Culver. Mrs. Reed discussed the topic, "A Public Health Nurse for Marshall County."

The May meeting will be a luncheon at Notre Dame and a conducted tour of their Art Museum.

We will have a picnic for our families in June. We are getting a box of samples ready to send to Europe.

Mrs. Hogle was chairman of the Woman's Division in the Infantile Paralysis Drive.

Mrs. C. R. Graham is the county chairman of the Marshall County Chapter of the Foundation for Infantile Paralysis.

Mrs. Reed is organizing a campaign for one or more Health Nurses.

NORTHEASTERN ACADEMY OF MEDICINE

Mrs. H. O. Williams, President

The Woman's Auxiliary to the Northeastern Medical Academy was handicapped by the irregularity of the meetings of the doctors. They were disbanded during the war, and are still not functioning smoothly. The group comprises the members of the four counties, which makes our meetings dependent on theirs, for transportation reasons.

We had but three meetings during the year; one, a joint meeting with the doctors; one, on medical legislation; and one social. We did not participate in the committee activties, as the club elects to remain a social group. However, I am happy to say that, with so little to hold them together, and no active working program, there were twenty-eight paid-up memberships, just because we were proud to belong to the Woman's Auxiliary.

PORTER COUNTY

Mrs. J. C. Brown, President

The Women's Auxiliary of the Porter County Medical Society was organized May 8, 1940, and has met regularly, to date. There are thirteen paid members. We anticipate two new members next year, as their husbands are returning to private practice after service in the armed forces. We subscribe to the *Bulletin* and sold eighteen *Hygeia* subscriptions in the past year. As an auxiliary we support the Porter County Hospital Guild and subscribed to the *Hygeia* for the hospital reading room. We were responsible, through the Guild, for a reading program for the hospital patients. Most of our work is accomplished in an indirect manner through our members and other organizations. In this manner we were responsible for two programs at the Women's Club, one on the Wagner-Murray-Dingell Bill, and the other on the doctor's insurance program.

We hold our meetings in the homes of members. A social time is enjoyed at the dinner table, as we have a carry-in dinner. This is followed by a business meeting and a program arranged by the program committee. Our programs deal principally with subjects relating to the medical field, such as excerpts from "Medical Economics," the *Bulletin*, and reports concerning the latest developments of the various medical bills pending in Congress. Our next speaker will be a representative from the Public Health Department. We feel our greatest gain is our understanding of each other, which has resulted in a feeling of good fellowship. We are pleased to report we have no deceased members.

ST. JOSEPH COUNTY

Mrs. Keith Selby, President

Officers for the year 1946-1947 were:

President ---------- Mrs. Keith Selby
Vice-President ---------- Mrs. Charles Savery
Secretary ---------- Mrs. Raymond E. Nelson
Treasurer ---------- Mrs. L. G. Ericksen

Meetings have been held in October, November,



FLEXIBILITY

Pediatricians recognize the advantages of flexibility in prescribing infant feeding formulas, as the protein, fat, and carbohydrate requirement may vary with the individual baby. Formula preparation with CARTOSE* is simple, rapid, and accurate.

CARTOSE supplies carefully balanced proportions of nonfermentable dextrins in association with maltose and dextrose. Due to the time required for hydrolysis of the higher sugars, absorption is spaced. This lessens the likelihood of distress attributable to the presence of excessive amounts of readily fermentable sugars in the intestinal tract at one time.

When supplementation with vitamins of the B complex is indicated, KINNEY'S YEAST EXTRACT* is suggested for routine incorporation in the daily feeding. The full daily dose is simply added to the twenty-four-hour formula.

KINNEY'S YEAST EXTRACT is prepared from a specially cultured yeast and contains all the known factors of the B complex in natural, palatable form.

CARTOSE and KINNEY'S YEAST EXTRACT are offered for use under the guidance of physicians. They are available only at drugstores.

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H. W. KINNEY & SONS, INC. (Kinney trademark) **COLUMBUS, INDIANA**

January, February, April, and May. A varied program was arranged for each meeting.

The objects of the Auxiliary have been threefold: (1) To promote friendship among physician's wives; (2) to study medical legislation; (3) to promote the sale of *Hygeia*.

A get-acquainted tea was held at the October meeting, and a tea, along with election of officers, was held in May. Members enjoyed dinner together in January, after which a review of the book "East River" was presented. Dessert preceded the business session at the other three meetings. The social hour affords members an opportunity to meet each other and become friends.

In November, Mr. Ray E. Smith, executive-secretary of the Indiana State Medical Association, presented an informative discussion on "Mutual Medical Insurance, Inc." At the January and February meetings, a member was appointed to report on pending legislation concerning medicine.

Increasing the circulation of *Hygeia* is the major project of our organization. This year we presented fifty-two county schools with two-year subscriptions and in addition, presented eighteen gift subscriptions to beauty shops and various reading rooms in South Bend and Mishawaka. In the *Hygeia* contest, sponsored by the A.M.A., in which cash prizes were awarded to auxiliaries for obtaining the largest number of subscription credits, the St. Joseph County Auxiliary won third prize ($15), in group III.

Our Auxiliary bought a $10 tuberculosis Christmas Seal Bond and during the month of April members telephoned over five hundred persons in an effort to raise funds for the annual cancer drive.

There are one hundred eighteen members of the auxiliary. This number includes eleven new members added during the year. Average attendance at meetings has been forty.

VANDERBURGH COUNTY

Mrs. J. D. McDonald, President

Membership—Ninety-five active members and six guest members, an increase of nine active members over 1945-1946.

Hygeia Subscriptions—Quota eighty-seven. Subscriptions submitted ninety-four. Vanderburgh County percentage approximately 108 per cent.

Bulletin Subscriptions—Five.

Program 1946-1947—

September—Organization. Guest: Mrs. Samuel J. Petronella, President of the Woman's Auxiliary to the Indiana State Medical Association.

October—Child Welfare. Guest: Miss Marie M. Fischer, Director Vanderburgh County Department of Public Welfare.

November—Educational. Guest: Professor Dean Long, Administrative Assistant to the President of Evansville College. Topic: "College and the Veteran."

December—Social. The President's Tea for all active, associate, and guest members, at the home of the president.

January — Educational. Guest: Mrs. Russell Simpson. Review of "Born Yesterday," a play by Garson Kavin.

February—Social. Sweetheart Supper Dance. Hotel McCurdy.

March—Business Meeting. Election of Officers for 1947-1948. Adoption of revised amendments to constitution.

April—Medical Education. Inspection of St. Mary's Hospital and Nurses' Home followed by tea in the Nurses' Home.

May—Public Relations. Completion of plans for a definite civic project sponsored by the Auxiliary.

June—Social. Annual picnic at home of Mrs. C. W. Yeck.

Four hundred fifty pounds of drugs were collected by the auxiliary under Mrs. A. B. Scales.

The auxiliary members have been very active in every type of civic project sponsored by various local organizations. It is our aim to have at least one member of the auxiliary in every organization active in promoting the health and welfare of the community. The Red Cross still absorbs many hours of volunteer service. This year the auxiliary, as a unit, furnished three complete teams to work during the Red Cross drive. At the 1947-1948 meeting we hope to be able to say that we have our own project—in the meantime we shall continue to serve with P.T.A., Crippled Children, Red Cross, Public Health Nursing Association, Cancer Control, et cetera.

Officers elected for 1947-1948:

President	Mrs. Walter Dycus
1st Vice-President	Mrs. Edgar Engel
2nd Vice-President	Mrs. A. B. Scales
3rd Vice-President	Mrs. Charles Schneider
Recording Secretary	Mrs. Howard Slaughter
Corresponding Secretary	Mrs. W. D. Davidson
Treasurer	Mrs. Shirley Lang
Parliamentarian	Mrs. A. W. Ratcliffe
Historian	Mrs. Clarence Baker

VIGO COUNTY

Mrs. E. R. Haslem, President

The Vigo County Auxiliary has eighty members, with an average attendance at each meeting of forty-five to fifty members.

To begin our year 1946-47, the executive board meeting was held in September. Our objectives

PROLONGED *Barrier Action*



1—Precoitus. Effective occlusion of cervical os by "RAMSES" Vaginal Jelly.

2—One hour postcoitus. Barrier action maintained by film of jelly.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

3—Four hours postcoitus. Uterine os remains occluded.

4—Ten hours postcoitus. Occlusion still manifest—barring the passage of sperm.

The direct-color photographs shown above establish the prolonged barrier action of "RAMSES"* Vaginal Jelly. For photographic purposes, the jelly, which has a transparent clarity, was stained with a nonspermatocidal concentration of methylene blue.

In addition to the barrier action provided by its exclusive gum base "RAMSES" Vaginal Jelly immobilizes sperm rapidly.

Tests by an accredited independent laboratory, supported by clinical work of an outstanding research organization, confirm the lack of irritation and toxicity under continuous use. For dependability in spermatocidal jelly specify

Ramses VAGINAL JELLY

TRADEMARK REG. U.S. PAT. OFF.

Active ingredients: Dodecaethyleneglycol monolaurate 5%; Boric Acid 1%; Alcohol 5%.

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were outlined. The board decided on five educational, informational, and social activities to be held during the year. We are stressing the social for the reason that many charter members are active again, and Army wives are back, and also because many wives of new doctors in the city are affiliating with the Vigo County Medical Society. Therefore, it is really a get-together year.

At the first meeting, in October, which was a tea, we had two very interesting reports from the national auxiliary meetings in San Francisco—and secondly we had informational reports and discussions of the new plan of Mutual Medical Insurance, "The Doctor's Plan."

Our following meetings included: a covered dish luncheon; an annual guest dinner, having as our guest our state president, Mrs. Petronella; a tea, at which time we held election of officers and enjoyed a dramatic entertainment from Indiana State College.

Our final meeting, in May, will be a picnic at the lake home of Mrs. C. R. LaBier. In this program there will be a brief resumé by our historian of the history of the one hundred years of the American Medical Association.

Our Public Relations chairman reports that over four hundred pounds of drugs and medicine have been collected and sent to Medical and Surgical Relief Committee.

The *Hygeia* chairman reports that with the cooperation of the Vigo County Medical Society and their gift of $25 we have been able to place seventy-five subscriptions of *Hygeia*.

Again this year we have been active in the occupational therapy project started some time ago, and also assisted in selling Christmas seals.

WELLS COUNTY

Mrs. Truman E. Caylor, President

There are seventeen active members, out of a possible twenty-three members, in our Woman's Auxiliary. We have made a gain of six new members. However, in the same length of time we have lost four of our members; two have moved from Indiana, and we regret to have to report the loss by death of two of our members: Mrs. I. N. Hatfield, on October 31, 1946, and Mrs. Robert Sherman, our recording secretary-treasurer, on February 18, 1947.

Our meetings are held monthly, on the third Monday night of each month, at the Bluffton Country Club, with the husbands as our dinner guests. Following the dinner the doctors hold their County Medical Association business meeting while we go to one of the homes for our meeting. After the medical meeting the men join us again for a bite to eat before going home. Our attendance usually runs from twelve to fifteen members.

The meetings have been largly educational in nature though we have stressed the social side of the organization, too, with every meeting. At four of our meetings we have had outside speakers. For the November meeting we were especially privileged to have Mrs. Petronella, our state president, as our guest and speaker. The balance of our programs were prepared and given by members of our own auxiliary, from material found in current issues of current magazines, *Saturday Evening Post*, the *Atlantic Monthly*, *Journal of the A.M.A.*, *Hygeia*, and other material suggested and furnished us by our county health doctor, Mrs. Petronella, and state auxiliary program chairman.

Six of our doctor's wives have been very active workers in the County Health Drives, and in helping with the health work carried on by Parent-Teachers and our local sororities and other organizations. We have sent in fifteen subscriptions to *Hygeia* and six subscriptions for the *Bulletin*. We renewed subscriptions for *Hygeia* for the Parent-Teacher presidents of our Bluffton schools. Our public relations chairman, Mrs. Harold Caylor, reports several boxes of drugs and hospital supplies have been sent to New York to be sent to foreign fields, as requested.

We have had two joint meetings this year with the medical association. One was a Christmas party at Dr. and Mrs. Leonard Long's home. The other was a joint meeting at Dr. and Mrs. Harold Caylor's home. The county welfare director, Mrs. Paskett, talked at this meeting about "Adoption and the Welfare Work of the County as Pertaining to Children."

We have been fortunate in having Dr. H. B. Annis as our advisor and have had unusually fine interest and cooperation from the Wells County Medical Society as a whole. We think our little "coke dates" following our meetings have been particularly advantageous in promoting sociability, a better understanding, and closer relationship within the two organizations.

Every epileptic seizure takes its toll—psychically and somatically. Mental deterioration, extreme emotional instability and physical decline are generally the ultimate fate of the untreated.

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Your doctor, however, will tell you these ideas are false.

The truth is that medical science has accomplished a great deal in its attempt to control epilepsy, and today the outlook for most persons who have the disease is distinctly hopeful.

What is epilepsy?

In broad and simple terms, epilepsy is a disorder in which the patient suffers recurrent nervous seizures. These seizures—usually characterized by muscular convulsions and sometimes by the loss of consciousness—vary greatly in frequency, duration, and intensity.

The fundamental cause of epilepsy is unknown, although a variety of contributing causes have been established.

Contrary to popular belief, heredity as a rule does *not* play the major role in epilepsy. The chances that an epileptic will have an epileptic child are only about one in forty.

Can epilepsy be controlled?

Epilepsy most often begins in childhood or adolescence. In times gone by, a diagnosis of epilepsy was a dreadfully heavy blow. But today the doctor can usually give the parents—and the child—much encouragement and hope. The following figures explain why this is so:

In approximately one out of six cases, the disease eventually disappears—and disappears completely.

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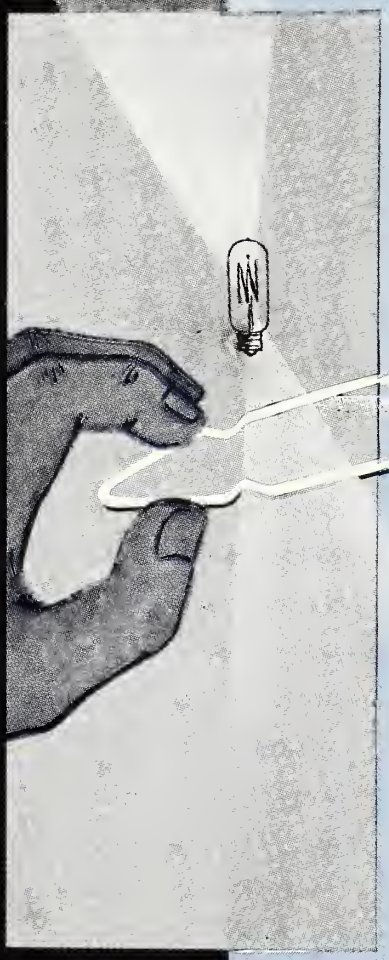
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STREPTOMYCIN*

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ROCHESTER, MINNESOTA

BEFORE I consider the new antibiotic, streptomycin, it is well to reflect a moment on what has happened in the last few years in the treatment of bacterial infections. Until approximately ten years ago the antibacterial agents for clinical use were, to say the least, feeble. The last ten years have seen the development of, first, the sulfonamides, followed by tyrothricin (gramicidin) then penicillin and, more recently, streptomycin. The development of penicillin was greatly accelerated by the stimulus of the recent war. Unfortunately, Fleming's observation, which was made in 1929, did not receive its deserved attention until the Oxford investigators isolated penicillin in a form suitable for clinical use in 1940. I think it can be stated fairly that experience in the development of the other antibiotic, penicillin, greatly fostered advances in the development of streptomycin.

An antibiotic is an agent which is elaborated by a microbe and which can be isolated and used in the treatment of infections commonly encountered in man. In other words, antibiotic agents are of microbial origin. There are, in general, three sources of antibiotic agents. One source is bacteria; another, molds and fungi; and the third is actinomycetes. Perhaps the most important antibiotic agent derived from bacteria is tyrothricin and the most important to date derived from molds and fungi is, of course, penicillin. Streptomycin is an example of an antibiotic derived from actinomycetes. The whole concept of use of antibiotic agents in treatment is based on the theory of bacterial antagonism. This is, by no means, a new theory. It has been known since the days of Pasteur. Unfortunately, most of the antibiotics known during the early days of bacteriology were too toxic for systemic use.

Streptomycin was described first by Schatz, Bugie, and Waksman in January, 1944. The substance was obtained from Streptomyces griseus; hence its name "streptomycin." The great interest in streptomycin lies in the fact that it is effective against certain important gram-negative organisms, many of which are not inhibited by penicillin. Furthermore, streptomycin appears to exert an antibacterial effect on Mycobacterium tuberculosis. At the Mayo Clinic studies on streptomycin began in the spring of 1944. Feldman and Hinshaw later reported on the possible effect of streptomycin in experimental and clinical tuberculosis. My interest in streptomycin has been in its use in the treatment of infections other than tuberculosis, particularly those due to sensitive gram-negative organisms.

It was evident from the early reports on streptomycin that this agent should prove effective in the treatment of infections due to Klebsiella pneumoniae (Friedländer's pneumonia) and such infections as ozena and rhinoscleroma in which this organism commonly can be isolated. In experimental studies streptomycin was found to be effective in the treatment of tularemia, and subsequent clinical studies confirmed this impression. Streptomycin also has an inhibitory effect on certain other important gram-negative organisms, such as those belonging to the colon-typhoid-dysentery group. It inhibits the growth of certain important organisms commonly found in the urinary tract, such as Proteus ammoniae and Aerobacter aerogenes.

At this point I would like to mention something about the bacteriologic facilities needed in the hospitals where patients receive modern-day chemotherapy for bacterial infections. Now that selective

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antibacterial agents are available, better and more adequate bacteriologic study of patients is important. This need poses a real problem to those interested in hospital administration. I am sure that most physicians can remember the time when the type of organism causing an infection was not particularly important because the treatment was largely empirical and, to say the least, not very satisfactory. Today good chemotherapy requires close collaboration between the bacteriologist and the clinician.

Physicians have now learned something about what happens to streptomycin once it is administered to the patient. In general, it behaves not unlike penicillin following its administration by the intramuscular, subcutaneous, or intravenous route. Streptomycin diffuses fairly readily throughout most body tissues. Levels in the blood are usually highest about two or three hours after the injection. By repeated injections the level of streptomycin in the blood can be built up rather high. In this respect it differs somewhat from penicillin. Streptomycin appears to be excreted rather readily by the kidneys. Approximately 60 to 80 per cent of the amount given will be excreted in the urine within twenty-four hours after administration. Streptomycin finds its way into the cerebrospinal fluid but appears to diffuse into this fluid more readily in the presence of inflammation. It does not appear to reach the brain tissue in significant concentrations. Streptomycin is excreted in bile and, therefore, should prove of value in the treatment of certain infections in the biliary tract. Streptomycin diffuses through the placenta and, therefore, if it is present in the maternal circulation, it is also present in the fetal circulation. In this respect it behaves much like penicillin. Small amounts of streptomycin also are excreted in breast milk. This means that the nursing infant may receive it by mouth. This fact should cause no great concern because its oral ingestion is not followed by its appearance in the circulation of the infant nor, for that matter, in the adult. The only possible result following oral ingestion is a reduction in certain bacteria in the intestinal flora. The failure of streptomycin to reach the general circulation following oral administration of even enormous amounts is of some importance. In this respect it differs from penicillin, for some penicillin will reach the general circulation after oral administration. As far as streptomycin is concerned, I think this attribute is perhaps fortunate because patients cannot obtain the material and treat themselves by oral administration. As I have already pointed out, the only result that can follow oral administration of streptomycin is a reduction in the sensitive bacteria present in the intestinal tract. This immediately suggests one possible future use of streptomycin; namely, its use in the preoperative preparation of patients for operations on the intestinal tract.

Streptomycin, unlike penicillin, is a fairly stable substance. Even in solution it can be kept a reasonable length of time without loss of potency. In early studies on streptomycin, the unit value was used. Recently quantities have been expressed in grams. One gram of streptomycin, as I shall use it henceforth in this paper, is equivalent to approximately 1,000,000 S units. In ordinary practice the solution used for intramuscular administration usually consists of 1 gm. of streptomycin per 5 cc. of distilled water. The average dose for adults is approximately 2 gm. and, in some instances, 3 or 4 gm. per twenty-four hours. The average daily dose for children is 1 gm.; however, on occasions as much as 4 gm. per day have been administered. In general practice, it is simply a matter of deciding on the amount to be used and then giving this amount in five to eight divided doses every twenty-four hours. This is usually given by either the subcutaneous or the intramuscular route.

Streptomycin also may be given by nebulization. For this purpose the solution should contain 50 mg. (50,000 units) per cubic centimeter. This method of administration is commonly used in the preoperative preparation of patients who are undergoing lobectomy for pulmonary suppurative disease. Penicillin and streptomycin are frequently combined and given by nebulization for this purpose. This results in a reduction of both the gram-positive and gram-negative organisms in the tracheobronchial tree. Streptomycin may be, and should be given by the intrathecal route in the treatment of meningitis. When spinal fluid is withdrawn, it is customary to administer 10 cc. of a solution containing 100 mg. of streptomycin. I have already mentioned that streptomycin may be given by mouth; 1 gm. may be administered every six hours and this usually will result in marked reduction in the number of sensitive bacteria in the bowel.

Clinical Results

Some of the most striking clinical results obtained to date with streptomycin have been those which followed its use in the treatment of tularemia. In this disease streptomycin has clearly established its value. In the past, patients who had tularemia were frequently ill for as long as twelve to sixteen weeks and many failed to survive. To date no failures have been reported in cases of tularemia treated with streptomycin. The average dose of streptomycin used has been 2 gm. per day for seven to ten days. The clinical improvement is dramatic and recovery has been uneventful in all forms of tularemia treated.

Bacteriemia and infections of the urinary tract due to Escherichia coli also have responded satisfactorily to streptomycin. There have been some failures in this group due to the fact that the organism was resistant or became resistant to streptomycin.

Rather satisfactory results have been obtained in cases of bacteriemia and infections of the urinary tract owing to Proteus ammoniae and Aerobacter aerogenes. Infections of the urinary tract should be treated intensively for a short period,

that is, five to seven days. Treatment should not be begun until foreign bodies and obstruction have been removed from the urinary tract. The presence of foreign bodies or obstruction favors the development of resistance to streptomycin.

The organism Hemophilus influenzae is sensitive to the action of streptomycin. It is not surprising, therefore, that satisfactory results have been obtained in the treament of influenzal meningitis with streptomycin. It is generally agreed, however, that in the severe cases treatment with streptomycin should be combined with sulfonamide therapy and probably also combined with serum therapy. Likewise, Hemophilus pertussis is sensitive to the action of streptomycin but clinical results to date have not progressed sufficiently so that any definite statements can be made about its value in whooping cough. Clinical trials are under way.

I mentioned earlier that the organism, Klebsiella pneumoniae, was sensitive to streptomycin. Use of this antibiotic has been found of value in the treatment of Friedländer's pneumoniae and it also appears helpful in the treatment of ozena. Unfortunately, the incidence of recurrence and the incidence of the development of resistance on the part of the organism is rather prominent in this group of infections.

In spite of the fact that the organisms belonging to the typhoid or paratyphoid group are reasonably sensitive to streptomycin in the test tube, the clinical results of its use to date in the treatment of typhoid fever have not been encouraging.

Although streptomycin for the most part is effective against gram-negative organisms, a few strains of Staphylococcus aureus, a gram-positive organism, also are sensitive to streptomycin. My colleagues and I have had occasion to see recoveries from staphylococcal bacteriemia when the organisms were resistant to penicillin but yielded to streptomycin.

Pasteurella pestis, the organism which causes plague, also is sensitive to the action of streptomycin. Plague, of course, is not an important disease in Indiana; however, it is encountered occasionally in certain parts of this country. From the studies on animals reported to date it is reasonable to assume that streptomycin should prove of value in the treatment of plague.

Early reports of an experimental nature suggested that streptomycin might prove of value in the treatment of undulant fever. The organism responsible for undulant fever is moderately sensitive to this antibiotic. Unfortunately, streptomycin was hailed as a cure for this rather common infection and this is not the case. Experience to date would lead me to conclude that streptomycin may be of some value in the treatment of undulant fever in the early acute stage, with or without positive blood cultures. I do not believe, however, that this beneficial effect is much greater than that which can be obtained by using three ten-day courses of treatment with one of the sulfonamides, such as sulfadiazine. It should be pointed out also that the results obtained in the early acute stages can be evaluated only with difficulty for many persons recover spontaneously and blood cultures become negative for the organisms even without treatment. In the treatment of so-called chronic undulant fever or brucellosis of months' or years' standing, I am convinced that streptomycin is of little or no value.

Streptomycin has been used in a variety of other miscellaneous infections but clinical experience to date is not great enough to justify any final statements. One of my colleagues, F. R. Heilman, found that certain spirochetes were sensitive to streptomycin. It was tried, therefore, in a few cases of early darkfield positive syphilis. The results were not convincing; however, the lesions while under treatment would become darkfield negative, but relapses occurred. In the light of our present knowledge we were using doses considerably lower than we are using today. In any event, I am inclined to believe that we will do well to continue the evaluation of penicillin in this disease before use of streptomycin is considered in the treatment of this infection.

I mentioned earlier the work of my colleagues, Feldman and Hinshaw, in connection with the use of streptomycin in experimental, as well as clinical tuberculosis. I am not qualified to speak with authority on the chemotherapy of tuberculosis. I will try to summarize the impressions I have gained from observing their studies as well as those carried out by other investigators. The evidence seemed clear from animal (guinea pig) studies that streptomycin exerted a definite suppressive effect on the course of this infection. This work naturally led to a widespread interest in its possible value in clinical tuberculosis. The effect of this substance in certain cases of pulmonary and extrapulmonary tuberculosis, including cases of cutaneous tuberculosis, renal tuberculosis, and tuberculous meningitis, have been investigated. I believe that these investigators are of the opinion that streptomycin exerts a suppressive effect but has not been hailed as a cure. As the matter stands, it is an important addition to standard forms of treatment. Unjustified publicity can lead to only one result. Patients will clamor for this new form of treatment and if its value is overstressed, patients may refuse conventional forms of treatment including sanatorial care. It is the responsibility of the medical profession to see that this does not occur. I believe it is the general impression that if streptomycin is to be used in the treatment of tuberculosis, it must be used for a long period, perhaps months. In this group of cases certain neurotoxic reactions may occur. I will mention those later.

Toxic Reactions

After subcutaneous or intramuscular administration of streptomycin pain may occur at the site of injection. This is not a troublesome nor serious

reaction. Certain toxic cutaneous reactions may follow its use, too. These reactions are not unlike those that follow the administration of penicillin to certain sensitive individuals. The reaction may take the form of a maculopapular rash or generalized urticaria. If use of the drug is discontinued the cutaneous reaction will usually subside. On occasion my colleagues and I have been able to continue administration of streptomycin after a cutaneous reaction has occurred by changing from one batch of streptomycin to another. In the management of the cutaneous reactions benadryl (B-dimethylaminoethyl benzhydryl ether hydrochloride) or pyribenzamine (N'-pyridyl-N'-benzyl-N-dimethyl-ethylene diamine hydrochloride) is rather helpful. The usual dose of benadryl or pyribenzamine is 50 mg. three times per day. Individuals who are sensitive and who handle the solutions of streptomycin in the laboratory or elsewhere may develop a real dermatitis. In other words, an occupational dermatitis may be encountered.

Perhaps the most important toxic reaction encountered in connection with the use of streptomycin is the neurotoxic effect on the eighth nerve. This reaction imposes a real problem but it is not insurmountable. As a rule it is not encountered when streptomycin is used for a short period, as for acute infections, although on occasion I have seen it develop soon after treatment is started. It is encountered rather frequently, however, when streptomycin is used for long periods, as is necessary in the treatment of tuberculosis. The reaction may take the form of vertigo which results from damage to the vestibular branch, or the reaction may take the form of a nerve deafness which results from damage to the auditory branch of the eighth nerve. Both reactions may occur in the same patient. Experience shows, however, that the reaction of the eighth nerve usually will subside if administration of streptomycin is discontinued soon after symptoms appear. This is a rather selective neurotoxic effect.

No other serious or significant toxic reactions have followed the use of streptomycin. There is no evidence to suggest that its use is followed by interference with normal renal function or that it has any toxic effect on the hematopoietic system.

Development of Resistance

I have mentioned before that certain organisms at times will develop resistance to streptomycin; in fact, some organisms will develop resistance to streptomycin with incredible rapidity. In the treatment of acute infections, therefore, intensive treatment for a short period of time is exceedingly important. Every effort should be made to reduce factors which favor resistance. Walled-off abscesses, when present, should be drained. Foreign bodies should be removed. Stasis and obstruction such as occur in infections of the urinary tract should be dealt with before treatment with streptomycin is begun. Finally, the pathogenic organisms should be tested for sensitivity before and during treatment. This testing necessitates frequent recourse to laboratory procedures which only the bacteriologist can furnish. As I said before, successful modern chemotherapy depends on close collaboration of the bacteriologist and the clinician. If an organism is resistant, or becomes resistant to streptomycin, treatment will necessarily fail. The development of resistance on the part of the organism is far more important in connection with streptomycin therapy than experience at the clinic has shown it to be with penicillin. In fact, I do not subscribe to much of the current comment concerning the fact that penicillin is losing its powers. The development of resistance on the part of organisms to penicillin, although it does occur, has not been a major problem in penicillin therapy.

Comment

To the investigator, all of these problems offer a great challenge. The past decade has been a great era in the treatment of important bacterial infections. Many problems remain unsolved but it is the hope of all investigators that in time agents effective in the treatment of most bacterial infections encountered in man will be developed.

DOCTOR RECOMMENDS STEPS TO AVOID REACTION FROM FLU VACCINE

An allergic reaction following injection of influenza vaccine, which caused death of a child, is reported by a Hempstead, N. Y., physician in the April 12 issue of *The Journal of the American Medical Association.*

Theodore J. Curphey, M.D., from the office of the Chief Medical Examiner, Nassau County, Meadowbrook Hospital, states that a very real danger exists in the administration of influenza and other vaccines prepared from cultures grown in chick embryo without first giving the patient a skin test to determine whether he is sensitive.

The author, explaining why there have been few deaths reported from allergic reactions in the past, states that "from available evidence it would appear that the percentage of sensitivity to egg protein in the general population is not greater than 10 per cent of the total number of allergic people. The estimate of the allergic population lies in the vicinity of 10 per cent, so that normally only one per cent of the general population can be regarded as allergic to egg protein. . . . It is known, however, that allergic children are generally more sensitive than adults."

The author recommends that attempts be made to purify further the various virus vaccines now becoming generally used so as to diminish the amount of reacting egg substances. He also recommends that patients receive skin tests for sensitivity to eggs and, if the skin shows a positive reaction, that the vaccine be administered in divided doses at short intervals.

In conclusion, the author says that "if the simple precautions which have been outlined are observed there should be little or no danger in continuing the vaccination of the civilian population with these agents, which the accumulated evidence shows to have definite immunizational value."

PARA-AMINOBENZOIC ACID THERAPY IN ROCKY MOUNTAIN SPOTTED FEVER: REPORT OF A CASE

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ROCKY MOUNTAIN spotted fever is an acute infectious but non-contagious disease. The causative organism is generally believed to be a gram negative rickettsia, Dermacentroxenus rickettsii. Transmission is by means of tick vectors. The crude fatality rate per the United States is 28.1 per cent.[1]

The multiplicity of treatments recommended for tick fever attest to the general unsatisfactory response to any one of them. Convalescent serum, transfusions, and autohemotherapy have been tried. Immune rabbit serum has been recommended by Topping.[2] Baker[3] has used neoarsphenamine dissolved in aqueous metaphen solution, administered intravenously. Sulfonamide drugs have no value.[4] Fitzpatrick[5] reports unsatisfactory results with penicillin in experimental tick fever, yet Edmunds[6] reports a case in which penicillin seemed to be of benefit. In 1944 Harrell[7] and associates recommended carefully controlled intravenous therapy in the form of plasma, whole blood, glucose, vitamins, and amino acids.

The possible value of para-aminobenzoic acid as a therapeutic weapon in rickettsial disease was first suggested by Snyder, Maier and Anderson[8] in their report on the survival rate of typhus-infected mice fed on a ration containing para-aminobenzoic acid. Grieff[9] and associates found para-aminobenzoic acid had a remarkable chemotherapeutic action on murine typhus in mice. They thought the effect was due to a stimulation of metabolism of the host cell.

Yoeman, Snyder, Murray, Zarafonetis and Ecke[10] studied the effect of para-aminobenzoic acid on louse-borne typhus. Their average treated case received an immediate dose of 4-8 grams of para-aminobenzoic acid, then 2 grams every two hours. Blood concentration of between 10 and 20 mgms. per 100 cc. blood was attained. The average amount required per patient was 127 grams. They found a tendency toward leukopenia and consider a white blood count below 3,000 per cubic millimeter a contraindication to para-aminobenzoic acid therapy. Their treated cases had a milder course, a shorter stay in the hospital, and developed fewer complications. The mode of action of the drug was believed to be an inhibition on multiplication of Rickettsiae inside the cells.

Hamilton, Platz and Smadel[11] found that para-aminobenzoic acid inhibited the growth of typhus Rickettsiae and prolonged the survival time of infected chick embryos. They consider this a specific action of the drug on the organism.

Tierney[12] studied the effect of para-aminobenzoic acid on tsutsugamushi disease. Eighteen cases were treated with an immediate dose of 8 grams of para-aminobenzoic acid followed by 3 grams every two hours. Blood levels between 30-60 mgms. per 100 cc. blood were reached. Leukopenia was the only toxic reaction noted. Three patients had secondary rise of temperature after therapy was stopped. The treated patients had fever of shorter duration, less severe symptoms, shorter periods of convalescence, and lower case fatality rate than the untreated controls.

Hamilton[13] found para-aminobenzoic acid twice

[1] Baker, G. E.: Rocky Mountain Spotted Fever, in *Tice's Practice of Medicine*, Hagerstown, Md., W. F. Prior Company, Inc., 5:49-67, 1944.

[2] Topping, N. H.: Rocky Mountain Spotted Fever, Treatment of Infected Laboratory Animals with Immune Rabbit Serum. *Public Health Rep.*, 55:41, 1940.

[3] Baker, G. E.: Rocky Mountain Spotted Fever. *Ann. Int. Med.* 17:247, 1942.

[4] Topping, N. H.: Experimental Rocky Mountain Spotted Fever and Endemic Typhus Treated with Prontosil or Sulfapyridine. *Pub. Health Rep.*, 54:1143, 1939.

[5] Fitzpatrick, F. K.: Penicillin in Experimental Spotted Fever. *Science*, 102:96-97 (July 27), 1945.

[6] Edmunds, P. K.: Rocky Mountain Spotted Fever: Treatment with Penicillin. *Rocky Mountain M. J.*, 41: 910-911 (December), 1944.

[7] Harrell, G. T.: Venning, W., and Wolff, W. A.: Treatment of Rocky Mountain Spotted Fever. *J.A.M.A.* 126:929-936 (Dec. 9), 1944.

[8] Snyder, J. C.; Maier, J.; and Anderson, C. R.: Report to the Division of Medical Sciences. *National Research Council*, Dec. 26, 1942.

[9] Grieff, D.; Pinkerton, H.; and Moragues, V.: Effect of Enzyme Inhibiters and Activaters on the Multiplication of Typhus Rickettsiae; *J. Exp. Med.*, 80:561-574, 1944.

[10] Yeoman, A.; Snyder, J. C.; Murray, E. S.; Zarafonetis, C. J. O.; and Ecke, R. S.: The Therapeutic Effect of Para-aminobenzoic Acid in Louse Borne Typus Fever. *J.A.M.A.* 126:349-356 (Oct. 7), 1944.

[11] Hamilton, H. L.; Platz, H., and Smadel, J. E.: Effect of Para-aminobenzoic Acid of the Growth of Typhus Rickettsiae in the Yolk Sac of the Infected Chick Embryo. *Proc. Soc. Exp. Biol. and Med.*, 58:255-262, 1945.

[12] Tierney, N. A.: Effect of Para-aminobenzoic Acid in Tsutsugamushi Disease., *J.A.M.A.* 131:280-285 (May 25), 1946.

[13] Hamilton, H. L.: Effect of Para-aminobenzoic Acid on Growth of Rickettsiae and Elementary Bodies with Observation on Mode of Action. *Proc. Soc. Exp. Biol. and Med.*, 59:220-226 (May) 1945.

as effective against Rickettsiae of Rocky Mountain spotted fever as against typhus, in his studies on the chick embryo. The action was thought to be on the enzyme system.

Anigstein and Bader[14] studied the effect of para-aminobenzoic acid on spotted fever in guinea pigs. In unprotected pigs the disease was 100 per cent fatal. When para-aminobenzoic acid (2 gm. with each 100 gm. of feed) was given prior to infection, in 80 per cent of the pigs the fever was either absent or abortive mild attacks occurred. When the drug was given during the incubation period 30 per cent remained afebrile. Since at autopsy some of the afebrile pigs showed typical pathological lesions of spotted fever, they consider the action to be suppressive rather than destructive to the organism.

Late in 1945 Rose and associates[15] reported the first clinical case of Rocky Mountain spotted fever treated with para-aminobenzoic acid. The case was diagnosed by means of a history of tick bite, the clinical picture of the disease, positive results of serological tests, and recovery of the etiological agent. One hundred seventeen gms. of para-aminobenzoic acid was given in an alkaline solution over a period of six days. The blood level reached 18.6 mg. per 100 cc. of blood. They noted improvement in the first twenty-four hours of treatment, with decline of fever, alleviation of headache, drowsiness, and general clinical improvement. The case made an uneventful recovery. The only toxic symptoms were nausea and mild leukopenia.

Following is a case of Rocky Mountain spotted fever treated satisfactorily with para-aminobenzoic acid. We hope that this clinical report will encourage others to investigate the possibilities of this drug in Rocky Mountain spotted fever.

Report of a Case

Mrs. N. H., a 52-year-old white female, was admitted to the isolation floor of the Indianapolis Methodist Hospital on August 9, 1946. Her chief complaints were severe occipital headache, chills, fever, and generalized macular-papular rash over her entire body.

The past history was remarkable only in that she had frequently displayed an urticarial response upon ingestion of tomatoes and quinine.

The present illness dated back to August 2 when the patient developed a severe occipital headache. The headache persisted and two days later the patient had a severe chill and temperature spiked to 105 degrees. Chills and fever continued in spite of aspirin, quinine, and sulfadiazine therapy. The rash first appeared early on the day of admission, on the ankles and wrist, and was macular in character. The spread of the rash was rapid and soon extended to the trunk. There had been no itching. The patient had been on a fishing trip in the latter part of July. On July 26 a wood tick had been removed from her back, inferior to the right scapula.

Physical examination revealed a moderately obese female, acutely ill, temperature 102 degrees, pulse 86 per minute, and respirations rapid and somewhat labored. A macular-papular rash covered the entire body but was not as dense on the trunk as on the extremities. It did not blanch on pressure. An enlarged right posterior auricular gland was palpable and tender. Blood pressure was 122 systolic, 80 diastolic. Heart, lungs, and abdomen were normal. The liver and spleen were not palpable.

Laboratory results on admission revealed a normal urine; RBC—4,500,000 per cubic millimeter; hemoglobin—14.5 grams per 100 cc., or 94 per cent; WBC—7,000 per cubic millimeter, with differential count of 83 per cent polymorphonuclears and 17 per cent lymphocytes; blood sedimentation rate of 18 millimeters in one hour. A chest x-ray was negative. Negative agglutinations were reported for B. typhosus, paratyphoid A and B, and undulant fever. The blood Mazzini was one plus positive; a blood Kahn was negative.

Two days after admission the Weil-Felix reaction was weakly positive in dilution 1:160. The next day the titer had increased and was reported strongly positive in dilution 1:320. The complement fixation test, as reported by the National Institute of Health, Bethesda, Maryland, was positive 1:128 for Rocky Mountain spotted fever and negative for endemic typhus. A blood culture was negative. Urine culture for typhoid organisms showed no growth.

On August 12 the patient's temperature dropped to subnormal. WBC remained 7,100 per cubic millimeter but the differential count showed a "massive shift to the left," with resulting values of 64 per cent polys., 12 per cent lymphocytes, 1 per cent monocytes, 22 per cent myelocytes, and 1 per cent blast cells. This was thought to be a poor response on the part of the body against a severe infection and a bad prognostic sign.

On August 13 a test dose of 200 mg. of para-aminobenzoic acid was given orally and was well tolerated. The next day a therapeutic regime was instituted. Two grams of enteric coated para-aminobenzoic acid, with one-half gram of sodium bicarbonate, was given every two hours orally, day and night. A blood level of 8.8 mg. per 100 cc. was reached in three days after 74.2 grams of para-aminobenzoic acid had been ingested. Following this therapy the patient showed decided clinical improvement. Her temperature was normal and the WBC—12,200 per cubic millimeter with a differential count of 72 per cent polys. and 28 per cent lymphocytes. However, since this level was below the recommended level of 10-20 mg. we shifted to para-aminobenzoic acid in capsule form. Every two hours 2.5 grams of the drug was given and a

[14] Anigstein, L., and Bader, M. N.: Para-aminobenzoic Acid—Its Effectiveness in Spotted Fever in Guinea Pigs. *Science*, 101:501-502 (June 8), 1945.

[15] Rose, H. M.; Duane, R. B., and Fischel, E. E.: The Treatment of Spotted Fever with Para-aminobenzoic Acid. *J.A.M.A.*, 129:1160-1161 (Dec. 22), 1945.

blood level of 16 mg. per 100 cc. was reached in two days.

Para-aminobenzoic acid therapy was discontinued on August 20. In a period of slightly more than six days 129.7 grams were given. By this time the rash had completely disappeared, the temperature had been normal for four days, and the patient was subjectively greatly improved. She was discharged asymptomatic on August 22, which was thirteen days after admission. On discharge the blood sedimentation rate was increased to 23 mm. in one hour. The Weil-Felix reaction was positive in dilution 1:640. The blood count was normal except for a mild leukopenia (4,500 per cubic millimeter); a mild glycosuria of ½ per cent was present in an otherwise normal urine.

Comment

Response to para-aminobenzoic acid was prompt in this case. Rash, headache, and mental confusion were eliminated two days after therapy was started. The temperature remained normal after three days of treatment.

Mode of administration. We noted no nausea following use of enteric coated tablets; however, the desired blood level was difficult to attain. After we shifted to plain capsules adequate blood levels soon were reached, but the patient became mildly nauseated.

Blood. A tendency to moderate leukopenia without a significant change in differential count was noted. The red blood count and hemoglobin remained essentially unchanged. Myelocytes noted in the peripheral blood stream prior to therapy soon disappeared entirely after treatment was instituted.

Urine remained unchanged except for appearance of mild glycosuria (¼ to ½ per cent). Blood sugar on discharge was normal, 101 mg. per 100 cc.

Precautions to be taken during para-aminobenzoic acid therapy. The total white blood count should be determined every second day. A total count below 3,000 is probably agreed indication for discontinuation of therapy. Frequent urinalyses in our case were normal, except the appearance of glycosuria was noted and persisted during therapy, although the blood sugar level was normal at all times. Samples from the para-aminobenzoic acid used on this patient when tested in vitro did not reduce Benedict's solution. Although we are unable to explain the glycosuria in this patient we recommend frequent urinalyses. Adequate fluid intake was maintained. Para-aminobenzoic acid blood levels should be made every third day and dosage adjusted to maintain an optimal blood level between 10-20 mg. per 100 cc.

Mode of action of para-aminobenzoic acid. The increase in agglutination titer of Weil-Felix reaction and increase in blood sedimentation rate on discharge would seem to point to a suppressive rather than a destructive action on the Rickettsiae. This would tend to support the observations of Anigstein and associates.[14] The final action is probably an immune reaction.

Summary

1. A proved case of Rocky Mountain spotted fever was treated with para-aminobenzoic acid.
2. Excellent clinical response was noted.
3. Two to two-and-one-half grams of para-aminobenzoic acid was given orally every two hours with sodium bicarbonate. Blood level between 10-20 mg. per 100 cc. was maintained.
4. Only toxic effects noted were nausea, mild leukopenia, and transient glycosuria.

SURGERY GIVES RELIEF TO MANY HIGH BLOOD PRESSURE PATIENTS

Two groups of Boston investigators report the beneficial effect on patients with high blood pressure following extensive removal of the sympathetic nervous system, which runs alongside the spinal cord, in the May 3 issue of *The Journal of the American Medical Association.*

The sympathetic system acts independently of the central nervous system, functioning unconsciously. It controls the arterioles, making them constrict during emotional stress. When they constrict, less blood can get into them from the arteries, and so the pressure of blood in the arteries goes up. High blood pressure, therefore, means that through some nervous or toxic influence the arterioles throughout the body are kept more or less constantly in a constricted state.

James L. Poppen, M.D., Department of Neurosurgery, and Charles Lemmon, M.D., fellow in neurosurgery, at the Lahey Clinic, present the results of this type of surgery on 100 patients with high blood pressure. They state that the results were good in 47 per cent, fair in 24 per cent, unsatisfactory in 22 per cent and fatal in seven per cent.

"One must not fail to realize that hypertension is the leading cause of death and is four times as deadly as cancer," state the doctors.

They believe that at present surgery for high blood pressure "increases longevity besides relieving symptoms and lowering the blood pressure . . . The criticism of this operation lies in the fact that the patient is hospitalized for a period of about four weeks."

Patients were carefully chosen for this type of operation. Patients over 50, patients who had a badly damaged heart, blood vessels or kidneys, or patients with early and mild cases of high blood pressure were not chosen for surgical treatment.

Another investigator, Robert S. Palmer, M.D., from the medical and surgical services and the Hypertension Research Committee, Massachusetts General Hospital, Boston, states that in November 1943 the status of 101 patients was reviewed. All had been treated by surgery involving extensive removal of the sympathetic nervous system. Sixty-two had been followed for one year or less after operation, 22 for one to two years, 14 for two to three years and three patients up to four years. Thirty-eight, or nearly 40 per cent, had normal or near normal blood pressures.

Three years later the results of surgical treatment were again evaluated medically with a review of 68 patients. Forty-seven of these patients are living; 16 of them with normal or near normal blood pressures and eight with blood pressures entirely normal. Twenty-one of the 68 patients had died.

EMERGENCY THORACIC SURGERY*

R. Morton Bolman, M.D.

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THERE probably is no field of surgery whose progress was so enhanced by the the massive experience of the war as that of thoracic surgery in general and the early management of severe thoracic injuries in particular. Thoracic surgery was already on a sound basis at the beginning of the war. The stage was set, so to speak, by the fine work of the pioneers and the war offered an opportunity to test, in a large number of cases, principles which were already well established. As is always true, some stood the test and some did not.

It would be unfair not to mention that endothoracic surgery would still be in the realm of the mysterious were it not for the farsightedness of the leaders in the field of anesthesia, because it has only been possible to advance this type of surgery step by step with the advances in that field. For this we must thank all those who contributed so generously to safe endotracheal and endobronchial closed anesthesia. Then, too, we must acknowledge the tremendous contributions of the bronchoscopist. Preoperative and postoperative bronchoscopy has saved many lives which were previously lost and made possible many operations previously thought impossible. To me, one of the outstanding accomplishments of the recent war was that the American soldier had the advantage of all these things within forty-five minutes to several hours after being wounded.

It might be well at the outset to quote a few statistics to show how much has actually been accomplished in the care of the injured chest. In interpreting these one must remember that with the more ideal conditions of a civilian hospital and civilian type injuries our record should be even more convincing.

In the wars between 1854 and 1870 the mortality of all chest wounds was 24 per cent to 37 per cent, and for those with penetration 47 per cent to 92 per cent. In our own Civil War, with 20,607 chest wounds reported, the overall mortality was 27.8 per cent and the mortality of the penetrating wounds was 62.5 per cent. These last, incidentally, are the most reliable statistics of any up to World War I. In the American Army in World War I the overall mortality for chest wounds was 24.05 per cent and for those with penetration 47.6 per cent. In World War II the overall mortality was 8.1 per cent and for penetrating wounds 14 per cent to 15 per cent. When one stops to think that in the Civil War nine out of ten chest wounds were produced by small arms fire, whereas in World War II eight out of ten were produced by ragged shell fragments, the advances in technique and care become even more apparent.

I would like to review briefly the mode of care in the seriously injured chest, evolved from the recent war, and present a few unusual cases I encountered.

Berry has stated the cardinal principles of traumatic thoracic surgery briefly and completely in two parts: first, the treatment of shock and hemorrhage, if present, by the institution of appropriate measures, and, second, the restoration of the thoracic viscera and of the cardio-respiratory physiology to their normal status. To elaborate on these principles, it has been found that severe chest injuries automatically divide themselves into two large groups.

The first, and this is by far the larger of the two, is that group in which a shocked patient is given blood, plasma, oxygen, sedation, and penicillin, and gradually, over a period of four to eight hours, his blood pressure rises, his pulse slows, his color improves, and he becomes an apt candidate for whatever intervention is necessary to make him well.

In the second and smaller group, the patient continues to decline or remains stationary in spite of all care and may die of pulmonary edema or massive hemorrhage unless corrective surgery is done at once, or he may die in spite of operative intervention.

In the first group, during the several preoperative hours, it may be necessary to aspirate the affected side of the chest to relieve the embarrassment of a collapsed lung and a shifted mediastinum. If so, two purposes are served. First, the pressure is relieved and respiratory physiology improved, and second, if the chest immediately refills with blood, we may be sure that a sizeable vessel is injured and that all efforts must be bent toward operative intervention as early as possible. This constitutes the only real emergency in the care of the injured chest. The others may all be handled symptomatically until the most ideal time for surgery arrives.

A case which illustrates this point is that of an American soldier wounded January 6, 1945, by shrapnel. The wound of entrance was in the region of the outer third of the left clavicle and four cms. below it. He was given blood and oxygen but didn't improve quite sufficiently to allow for surgery. A massive left hemothorax was obvious so the left side of his chest was aspirated. Twelve hundred cc. of blood was removed when the patient's condition began to deteriorate rapidly. The aspiration was stopped and more blood given. As soon as the blood pressure reached 100 mm/hg. he was explored, with blood running, by lateral and

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medial extension of his wound. The axillary vein was lacerated at a point where it lies directly on the bony thorax and was emptying blood directly into the thorax. The axillary vein was sutured, the chest drained, and the patient made an uneventful recovery. Thus aspiration of a hemothorax may be a diagnostic as well as a therapeutic procedure.

During the preoperative and postoperative period cough is a very necessary therapeutic aid, because the bronchioles usually contain blood and mucus which lead to incomplete aeration and atelectasis. In this connection, Sampson and Fitzpatrick describe blocking the intercostal nerves to the affected area with novocaine, or better still, novocaine in oil. This is a proved procedure and affords grateful relief in chest wall injuries besides allowing the patient to cough. The three or four intercostals supplying the injured region are blocked with novocaine near their origin, a simple procedure, and this may be repeated as often as necessary until healing has taken place. This, incidentally, is worthy of consideration in the treatment of the simple fractured rib. Novocaine is injected into the fracture site as well as at the point of origin of the supplying intercostal nerve and complete relief is offered without cumbersome strapping. This procedure is also useful in so-called "stove-in-chest" with paradoxical breathing, although here sandbag or plaster immobilization may be necessary as well.

Hemothorax is the commonest feature of the ordinary thoracic injury, being present in 75 per cent of all cases, open and closed. It is a well-proved fact that to leave a hemothorax is to court disaster. This is true even in closed chest injuries because empyema follows rupture of a lung just as frequently as it follows an open chest wound. The one irrefutable fact that has come out of the war is that all hemothoraces of any size should be aspirated early and frequently. The ideal locations for aspiration are either the sixth or seventh intercostal space in the midaxillary line or the eighth interspace in back. It was long felt that aspiration in these cases should be delayed because of fear of recurrence of the bleeding. It has been found that it is the exception for bleeding to recur following aspiration. Bleeding from the lung, once it has ceased, is not apt to begin afresh, and conversely, bleeding from an internal mammary or intercostal vessel cannot be arrested by merely leaving a large quantity of blood in the chest. Early aspiration has become the procedure of choice because (1) it relieves high intrapleural pressure; (2) it removes an excellent culture medium for bacterial growth; (3) it aids in early re-expansion of the lung, which is a definite advantage in limiting the area of empyema if infection develops; (4) it decreases the incidence of massive clotting in the pleural cavity; and (5) it prevents late fixation and contraction of the thorax with its concomitant respiratory invalidism.

Morrelli of the Italian Army suggested aspiration and air replacement at the time of World War I. This has been found not only unnecessary but harmful since it also favors a complete empyema if infection develops. The efficiency of early aspiration in hemothorax is attested to by Blades and Dugan, who report that, of 137 patients entering Walter Reed General Hospital from the European theater of operations, only seven had empyema and six of these were small. One hundred thousand units of penicillin in ten cc. of distilled water should be placed in the pleural cavity at the close of each aspiration, and adequate doses of penicillin should be given parenterally for five days after the injury. The patient with the injured chest is uniformly more comfortable when sitting up at forty-five degrees and, incidentally, early x-rays taken in this position give a much truer picture than those with the patient lying flat.

Traumatic pneumothorax is seen either alone or in combination with hemothorax. It is best diagnosed by the fullness of the affected side, the tympany, the absence of breath sounds, and the shifted mediastinum. The diagnosis may be confirmed by x-ray. Usually the frequent aspiration of large quantities of air and the instillation of penicillin are the only therapeutic procedures necessary. However, if control cannot be established in this manner, if sputum is found in the early aspirations, or the patient becomes febrile, the chest must be opened and the leak closed, either by suture or, if a major bronchus is open, by muscle transplant.

A farmer was hit in the chest by a large plank during the construction of a barn. He entered the hospital in a shocked, cyanotic condition. On examination the signs were those of tension pneumothorax on the right side. Twenty-two hundred cc. of air was aspirated immediately and one hundred thousand units of penicillin instilled into the chest. This was repeated at first every twelve and then every twenty-four hours. Steady progress toward recovery was made. The patient remained in the hospital three weeks and is now back at work on his farm.

In the patient with a severely injured chest whom you are trying to ready for early surgical intervention, tension pneumothorax is best managed by inserting a large caliber needle into the second intercostal space in the midclavicular line and attaching it by rubber tubing to a water seal drain. The presence of a tension pneumothorax may be confirmed without x-ray by inserting a needle into the pleural cavity to which is attached a twenty cc. syringe whose plunger slides freely. In the presence of increased tension the plunger is pushed out.

Open pneumothorax or so-called "sucking wound" of the chest may be handled by temporarily packing the wound with sterile vaseline gauze and strapping it shut with adhesive tape until the proper time for debridement and closure arrives. In addition, the patient should always lie on the injured side. If many ribs are broken an adhesive strap with many tongue depressors incorporated

is an invaluable aid in stabilizing the chest wall and allowing for more nearly normal respiration.

Wounds of the esophagus and trachea require prompt attention if a mediastinitis is to be averted. As a case for illustration, a soldier was shot by a sniper at 2:00 A.M. Christmas Day, 1944, in Germany. He entered the hospital with a wound of entrance almost at the site of election for tracheotomy and a wound of exit through the body of the left scapula. His face, neck, and trunk were badly swollen and crepitant with subcutaneous emphysema. His first x-rays showed bilateral tension pneumothorax and collapse of both lungs. His blood pressure was 80/60 and his pulse 130. Tracheotomy was done and twelve hundred cc. of air was aspirated from each side of the chest. He was then replaced in the shock ward, a Levine tube was cautiously passed and large doses of penicillin started. It should be mentioned that, in addition to his chest wounds, this patient had a compound comminuted supracondylar fracture of the right humerus and a perforating wound of the right foot. After four hours his condition was somewhat improved. The tracheo-esophageal fistula was repaired under local anesthesia through an approach from behind the sternocleidomastoid muscle. A large Penrose drain was inserted to the esophagus. The patient was fed by Levine tube, his other wounds were cared for the next day, and after seven days he began to take liquids and made a good recovery.

Whole blood and plasma played a large role in the recovery of these patients. In our series of thoracic and thoraco-abdominal wounds, during the preoperative, operative, and postoperative periods, an average of two thousand cc. of blood and seventeen hundred cc. of plasma was given. Oxygen is always helpful, from the time of admission until twenty-four hours after surgery, and then as necessary.

Morphine should be restricted to grs. 1/6 per dose and should be given slowly intravenously in the early wounds because of its slow effect when given intramuscularly in shock patients.

The one patient who tolerates intravenous fluids and anesthesia poorly is the one with pulmonary hematoma from a blast or crushing injury. He can be recognized by his severe cyanosis in spite of oxygen, his wet lungs, and marked limitation of his respiratory movements. In one of the most severe blast injuries of the lungs we encountered, the patient died after eighteen hours in the shock ward without surgery. The diffuse hematoma could be seen by the mottled appearance of the lung fields and at autopsy the lungs had the appearance of severe red hepatization as seen in lobar pneumonia. It is only by conservatism and repeated bronchoscopic aspirations that these patients may be coaxed through their first four or five days. Bronchoscopic and catheter aspiration plays a very important role in all chest surgery but certainly most of all in the injured chest.

Cardiac wounds are a field of study in themselves. Those who live long enough to receive surgical attention have a fair chance of recovery. Certainly these cases should not be operated until a supply of three or four pints of blood is at hand and the blood should be running well through a large needle so that if difficulty arises the blood may be given very rapidly for a little while. If the wound is recognized preoperatively as primarily cardiac, the anterior approach is the most desirable. An incision is made from the second to the fifth interspace along the left border of the sternum and joined by a lateral incision in the third interspace. The best means of controlling the heart while attempting to repair it is by means of a so-called "Beck's traction suture" in the apex with longitudinal traction. The heart tolerates rotary traction very poorly but longitudinal traction is tolerated very well. Heart wounds are usually repaired by interrupted or mattress sutures of medium weight silk.

On May 16, 1946, a young man was accidentally shot in the chest. The wound of entrance was in the fifth interspace anteriorly and the wound of exit was in the eighth interspace posteriorly. He entered the hospital at midnight with embarrassed respirations, cyanosis, blood pressure 70/50, and pulse 110. He was placed in an oxygen tent and one thousand cc. of plasma was given while donors were being cross-matched. In his first x-ray one could see a hemothorax and a suspicion of widening of the pericardial shadow. The abdomen was fairly rigid and the bowel sounds were absent. By four o'clock in the morning he had had one thousand cc. of blood and one thousand cc. of plasma, but his condition failed to improve materially. He was taken to the operating room and a thoracotomy of the anterior "T" type, previously described, was done under endotracheal gas-oxygen-ether anesthesia.

He was found to have a wound of the pericardium and a grooved wound of the myocardium of the left ventricle, a perforation of the lower lobe of the left lung, the diaphragm, the stomach, and a small wound of the spleen. The upper two-thirds of the stomach was in the chest and a lacerated branch of the left gastric artery was pumping blood freely. The patient was shot just after a wedding reception and his left chest contained a mixture of food, spiritus frumenti, and blood. The cardiac contusion was inspected and let alone inasmuch as it seemed to be handling itself rather well. The diaphragm was opened widely, the stomach was delivered into the chest, repaired, and replaced in the abdomen. The splenic wound was minor and not bleeding, so it was left. The diaphragm was closed with heavy interrupted silk sutures. The lung was repaired and re-expanded and the chest was generously irrigated with two thousand cc. of warm normal saline. One hundred thousand units of penicillin in distilled water was placed in the pleural cavity and the chest was closed in layers with a 20-F catheter emerging through a small stab wound. This was attached

to a water seal bottle and every four hours was clamped off for one-half hour after the instillation of forty-thousand units of penicillin. At the end of forty-eight hours the catheter was removed and the patient was up in a chair. He developed a serosanguineous effusion and had to be aspirated, in all, five times. He left the hospital in three and a half weeks and has since returned to his trade as a machinist.

A logical question might be, "Which ones need open thoracotomy and which may be safely treated expectantly by supportive measures, aspiration, and penicillin?" The general consensus is that the following need thoracotomy:

1. Large sucking wounds.
2. Knowledge of the presence of organic foreign bodies such as clothing, wood, et cetera.
3. Foreign bodies of any type larger than two cms. in diameter.
4. Increasing hemothorax which rapidly replaces itself when aspirated.
5. Failure to improve on adequate shock management.
6. Suspicion of injury to vital structures, such as the heart, esophagus, or a major blood vessel.
7. Suspicion of lung perforation by a rib fragment.
8. Suspicion that the wound also involves the abdomen, so-called thoraco-abdominal wound.
9. Uncontrollable tension pneumothorax or subcutaneous emphysema.

Following thoracotomy every effort must be bent toward re-expansion of the injured lung. These include early ambulation, deep breathing exercises, early movement, bronchoscopic aspiration, if necessary, encouraging the patient to cough, and the maintenance of a pleural cavity as nearly empty as aspiration will allow.

One of the most serious but most fascinating types of chest injury is the thoraco-abdominal wound, which, as its name implies, involves both the thorax and the abdomen. About 10 per cent of chest wounds involve the abdomen, as well. In World War I the mortality with these wounds was about 60 per cent. A preliminary report on World War II hints at 25 per cent. In our series of twenty-nine thoraco-abdominal wounds there were seven deaths (24.1 per cent). The most pertinent observations that have been made concerning this type of injury are:

1. X-ray and fluoroscopic examinations of the abdomen must be done in all cases of chest wounds, since, in a surprising number, the missile has been found to have entered the abdomen.
2. Complete exploration of the abdomen through the diaphragm cannot be performed and should not be attempted except in cases where the path of the missile indicates that all the damage is within reach by this approach.
3. In right-sided injuries the abdominal damage is usually confined to the liver, and in these cases trans-diaphragmatic approach alone is more frequently justified. However, bile in the pleural cavity is a serious matter so that ordinarily the liver wound is packed lightly (fibrin foam), the end of the gauze is pushed down over the liver edge, and the diaphragm and chest are closed. The end of the pack can then easily be brought out through a small right-sided subcostal incision. This pack should be left in for from two to twelve days.
4. If the chest wound is sucking it must be closed after debridement with as little intrapleural manipulation as possible before laparotomy is performed.
5. Shock is profound in these cases and adequate transfusions of whole blood (often as much as 1500 cc.) are imperative.
6. The chest should be drained by an intercostal catheter with a water seal drain or flutter valve.

Empyema and clotted hemothorax form the two major late complications of chest trauma. In the former, early recognition by smear, odor, and culture of the aspirated fluid, and prompt institution of closed drainage, followed by rib resection and adequate exposure of the infected areas, has been considered the best management in these cases. It is certain that penicillin and sulfa have prevented many, many empyemas but it is felt at present that once empyema develops the treatment is still surgical and the drugs merely hide the symptoms while the disease progresses.

In clotted hemothorax that repeatedly resists aspiration the procedure of choice is seventh rib resection and thoracotomy, with evacuation of the clot between the third and tenth weeks, with or without decortication of the affected lung, which amounts to removing the scarred, fibrous capsule of the lung, piecemeal. Blades and Dugan believe that decortication is indicated if, after the clot is removed, the lung appears too rigid to allow re-expansion.

Another troublesome sequela of thoractomy is intercostal neuritis with pain. The best treatment for this is its avoidance by care at operation and the avoidance of perichondrial sutures in closing the chest, since one damaged nerve causes no symptoms but two or three in a row do. Tudor Edwards has practically proved that rib-spreading retractors cause no nerve injury if used judiciously.

The intelligent management of the injured chest, then, in the words of Debakey, depends on an early recognition of abnormal cardio-respiratory physiology and the restoration and stabilization of the mechanisms thereof before operative intervention is undertaken, and the judicious timing and selection of surgical procedure with a view to the re-establishment of normal physiological processes.

It is impossible to estimate this soon after the war what its effect will be on thoracic surgery in

general. Dragstedt reports that in over one hundred vagotomies for peptic ulcer, done through the chest, there has been but one mortality and that was due to pylorospasm in an uncooperative patient. In our experience with vagotomy, although much more limited than Dragstedt's, the postoperative course and recovery seems uniformly uneventful.

The inferior portion of the esophagus may now be approached with relative safety through a thoracic or combined thoraco-abdominal incision. Embryological abnormalities of the circulation, such as patent ductus arteriosus, may be attacked with an operative mortality comparable to that of gastric resection. Open thoracotomy, once a much-feared procedure, may now be carried out with much the same mortality as that of major abdominal surgery.

TERTIARY SYPHILIS OF THE LARYNX: ITS DIAGNOSIS, PATHOLOGY AND TREATMENT*

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RECENT literature concerning tertiary syphilis of the larynx is rare. Only nine articles on this subject in the English language can be found in the "Quarterly Cumulative Index Medicus" since 1926. In the literature prior to 1926 syphilis of the larynx is discussed with increasing frequency, and many papers on the subject are found in British medical literature. This scarcity of literature is possibly an index to the number of cases of tertiary syphilis of the larynx which have been seen by laryngologists in the past fourteen years.

This paper deals with the diagnosis, pathology, and treatment of tertiary syphilis of the larynx. It is intended to call to our attention that this condition is still seen but with less frequency than formerly.

Diagnosis

The diagnosis of tertiary syphilis of the larynx may be very difficult because tertiary lesions may simulate nearly any other chronic disease found in the larynx, and the symptoms produced by tertiary lues of the larynx are the same as those produced by many other laryngeal conditions. The greatest single aid to diagnosis of tertiary lesions of the larynx is to think of it as a possibility. In this day when we are seeing so few cases of this nature we are apt to forget that such a condition can exist. The one most prominent symptom of this laryngeal condition is hoarseness of some degree; it may be intermittent or continuous; it may be only a slight huskiness or a complete aphonia depending upon the location and extent of the lesion. In the cases reviewed I have not found a single case in which hoarseness was not present at some time during the disease. Usually it is this symptom that causes the patient to consult the laryngologist. As a rule, pain is not a common symptom early in the development of tertiary lesions of the larynx but is often "associated with ulceration of a gumma affecting the free edge or lingual surface of the epiglottis, the aryepiglottic fold or the posterior surface of the cricoid lamina".[1] A rapid breaking down of a gumma in any location of the larynx may also give rise to pain,[2] and Imperatori[3] considers pain a frequent symptom in the tertiary stage of syphilis of the larynx. As a rule cough is not necessarily a complaint in the early stages, but Laurens[4] lists expectoration as a symptom but does not say whether or not it is preceded by cough. Dysphagia is not necessarily complained of early but is always present when ulceration involves the epiglottis or ulcerates deeply between the root of the tongue and the lateral pharyngeal wall. In regard to dysphagia as a symptom it may be said that it is present only when the lesion is situated at the upper aperture of the aerodigestive crossway. Dyspnea is purely a problem of a decreased opening of the airway due either to fixation of one or both vocal cords as a result of the infiltrating lesion or to the size of the lesion per se causing a mechanical obstruction. Edema may suddenly develop about the site of the lesion as a result of exertion or the administration of a general anesthetic and cause alarming symptoms of suffocation. Stridor is apt to come on slowly, and the patient becomes accustomed to his contracted airway and may not notice it. Stridor is usually increased at night.

A diagnosis of tertiary syphilis by direct or indirect laryngoscopy alone may prove to be diffi-

* Presented before the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

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[3] Imperatori, Chas. J. and Burman, Herman, J.: *Diseases of the Nose and Throat,* J. B. Lippincott Co., Philadelphia, 1935.

[4] Laurens, George: *Oto-Rhino-Laryngology,* William Wood, New York, 1922.

cult because of the similarity of these lesions to those of a different etiology. However, there are certain local appearances which are strongly suggestive of syphilis. The disease is more apt to attack the anterior part of the larynx;[5] and when the gumma breaks down, the edges of the resulting ulcer are well defined, punched out, and undermined. Imperatori[6] states that the gumma may be single or multiple and occur at any place in the larynx. Bruck[7] points out that frequently in anemic or debilitated patients all signs of inflammatory reddening around the ulcer or infiltration may be absent. In view of the number of conflicting opinions and observations, it can safely be said that in the majority of cases a positive diagnosis of tertiary syphilis of the larynx cannot be made merely from the laryngoscopic appearance alone.

Another important aid in the correct diagnosis of laryngeal lues is a definite history of luetic infection. The initial infection usually has occurred many years before, but a negative history of infection should not dispel the thought of it from our minds since the negative history may be due to ignorance of the infection, especially in the female, or to a desire on the part of the patient to conceal the truth. The complement fixation tests are of undoubted value when positive, but a negative test, like a negative history, is not always a criterion for the absence of syphilis, especially in its tertiary stage. Another useful means of obtaining a correct diagnosis is a biopsy, and this should be done in all cases which are in the least doubtful.

The differential diagnosis of syphilis can be very difficult. The most common conditions to be considered are malignant infiltration, tuberculosis, and the simple inflammatory processes of a chronic nature which affects the larynx. In many cases a correct diagnosis can be arrived at only by a circuitous route. Another problem to be borne in mind in the diagnosis is the existence of a tertiary lesion complicated by a malignant or a tuberculous lesion. In a case of tertiary lues complicated by a malignancy a biopsy is of importance along with the Wassermann test. In cases complicated with tuberculosis repeated sputum examinations and x-rays of the chest are valuable since all tuberculosis of larynx is thought to be secondary to pulmonary tuberculosis. Of interest along this line is a case reported by Engelsher.[8] The patient complained of chronic hoarseness and gave a history of luetic infection many years previously. His Wassermann was positive and he also had active pulmonary tuberculosis. The laryngeal lesion was finally diagnosed as syphilitic and showed marked improvement under antiluetic therapy.

Another case of interest is one reported by Gregory.[9] The patient had a laryngeal luetic crisis complicated by diphtheria. There were paroxysms of severe dyspnea, each lasting about three minutes. Between attacks she was perfectly comfortable. A throat culture revealed diphtheria and the Wassermann was positive. The patient was treated with antitoxin for the diphtheria, from which she recovered, and the antileutic treatment consisted of neoarsphenamine, .45 grams intravenously as an initial dose, along with a daily mercury rub. After the first injection the hoarseness began to clear and she had no further paroxysms of dyspnea.

We must not forget, however, that patients with a positive luetic history or a positive Wassermann may have other diseases of the larynx not due to syphilis and should be treated accordingly. This is especially true in the older age group. It should be remembered that many people die with their syphilis and not as a result of it. It should be stated parenthetically that syphilis may affect the larynx in other ways than locally, such as by invasion of the bulbar nucleus causing recurrent paralysis, or by involvement of this nerve anywhere in its course, or by a peripheral neuritis.

Pathology

The pathology of syphilis of the larynx is essentially the same as the pathology of syphilis elsewhere in the body, with, however, the added danger of suffocation as a result of mechanical obstruction. Moure[10] gives a simple, yet complete, classification of tertiary lesions of the larynx as follows:

(1) Gumma
(2) Ulceration
(3) Perichondritis
(4) Pseudo-polypoidal Form
(5) Laryngeal Stenosis
(6) Paralysis.

Circumscribed gummatous tumors usually have a smooth reddish surface and are clearly defined by peri-inflammatory infiltration. When the gumma is about to become soft, small yellowish projections appear where the crateriform ulceration takes place. These projections may become contiguous and give the mucous membrane an irregular mammillary appearance. Thom[11] makes the statement that gumma is not so frequent a lesion as gummatous infiltration and says that a gumma is not usually recognized until it breaks down. Gummatous infiltration does not always go on to ulceration, but the inflammation may subside and be transformed into fibroid tissue. The infiltrated gumma causes much distortion of the surrounding tissues and structures.

Some pathologists and laryngologists do not differentiate sharply between gumma and gummatous

[5] Jackson, Chevalier, and Coates, George M.: *The Nose, Throat, and Ear and Their Diseases*, W. B. Saunders Co., Philadelphia, 1930.

[6] Imperatori, Chas. J. and Burman, Herman, J.: *Diseases of the Nose and Throat*, J. B. Lippincott Co., Philadelphia, 1935.

[7] Bruck, Alfred: *The Diseases of the Nose, Mouth, Pharynx and Larynx*, Rebman Co., New York, 1910.

[8] Gregory, Lewis T.: Laryngeal Crisis with an Unusual Complication, *J.A.M.A.* 74:793, Mar. 20, 1920.

[9] Engelsher, D. L.: Coexisting Active Syphilis of the Larynx with Active Pulmonary Tuberculosis, *J.A.M.A.* 89:284, July 23, 1927.

[10] Moure, E. J.: *Diseases of the Pharynx and Larynx*, Rebman Co., 1909.

[11] Thom, Burton Peter: *Syphilis*, Lea and Febiger, Philadelphia and New York, 1922.

infiltration. Authorities who do make this differentiation do not make their descriptions of the difference very clear. It seems, however, that gummatous infiltration refers to a more diffuse lesion than gumma, which is usually a well-defined single lesion.

Ulceration usually constitutes the second stage of gumma or gummatous infiltration, and the first phase may develop so rapidly that ulceration is present by the time medical aid is sought. Ulceration proceeds rapidly in breadth and depth and soon penetrates through the submucous tissues and reaches the cartilage which then undergoes necrosis. The sharply defined edges of the ulceration have an indented, fringed appearance and may be undermined by the ulcerative process. These semidetached masses of tissue may become free in the larynx and cause obstruction to breathing if not removed. The gummatous ulcer is the most frequent syphilitic manifestation seen in the larynx.[12]

Perichondritis may not be the result of ulceration, for the perichondrium and cartilages may be attacked first with resultant secondary ulceration. In this form the vocal apparatus, especially the cartilages and vocal cords, may be seriously affected by large necrotic ulcerations. In primary perichondritis there is visible external swelling, and the cartilage is painful to the touch. External fistular tracts may be seen, which may penetrate internally.

Pseudo-polypoidal diffuse degenerations may invade the whole larynx; however, they are a rare manifestation of laryngeal syphilis and are most common in the posterior commissure. These degenerations may resemble pachydermia of the larynx.

Laryngeal stenosis is a frequent end result of tertiary syphilis of the larynx. Scar tissue may be abundant as a result of the deep and extensive defects caused by the destructive ulceration and necrosis. Syphilitic scar tissue is especially liable to contract, resulting in severe disfigurement, stenosis, and distortion, even causing incurable functional disorders. Stenosis may be caused by adhesion of the two vocal cords or by formation of a true membrane between them. In other cases the crico-arytenoid joint may become ankylosed. A true annular constriction of the larynx may also be an end result. Dyspnea, as a result of laryngeal stenosis, may come on gradually as the newly formed scar tissue contracts. However, if the lesions have been severe enough to produce this amount of scar tissue, dyspnea has usually resulted previously from the mechanical obstruction of the earlier lesions, and tracheotomy has probably been performed before this stage of scarring is reached.

Paralysis may be caused by compression of the recurrent laryngeal nerve by infiltrated glands. Paralysis may be the result of myopathic changes or may be simulated by an ankylosed crico-arytenoid joint. Peripheral neuritis, as a result of syphilis, may attack the recurrent laryngeal nerve and in this way cause vocal cord paralysis. Paralysis of the vocal cords in a syphilitic may be due also to central involvement of the laryngeal nerves with no lesions present in the larynx.

[12] Bruck, Alfred: *The Diseases of the Nose, Mouth, Pharynx, and Larynx*, Rebman Co., New York, 1910.

Treatment

The treatment of tertiary syphilis of the larynx resembles that of tertiary syphilis elsewhere in the body with the exception that life-saving measures, most commonly tracheotomy, may be needed. This may be necessary under adverse conditions due to sudden attacks of suffocation resulting from acute edema of the laryngeal structures or the breaking loose of a necrotic piece of tissue which occludes the airway. In most cases of tertiary lesions of the larynx that show signs of dyspnea, it is considered wise to do a tracheotomy before this distressing symptom becomes too severe and thus avoid emergency surgery. It has also been found that some cases have an increased edema of the lesions shortly after treatment is begun, which causes acute obstruction of the airway. This is most often true if the treatment consists of potassium iodide. That tracheotomy before the case is desperate is a wise procedure is shown by cases reported by Moore,[13] Peacock,[14] and Harrison.[15] All cases reported by these three authors had a tracheotomy, not as an emergency measure, but to prevent the emergency. Weinstein[16] reports a case of syphilis of the larynx in which dyspnea was not present and a tracheotomy was not performed. The patient made an uneventful recovery with antiluetic therapy. If any dyspnea, even slight, is present, a tracheotomy should be performed as a safeguard against an emergency.

The actual treatment of the syphilis includes intravenous use of neoarsphenamine, intramuscular injections of bismuth salicylate and mercury salicylate. Mercury by inunction is still recommended as a safe and trustworthy treatment for patients who will carry it out. It must be remembered that tertiary syphilis of the larynx is found more often in elderly individuals, and the treatment of these older people must not be too severe. If a tracheotomy has been performed potassium iodide in increasing doses, along with bismuth salicylate intramuscularly often gives very good results. Mixed treatment was used by the older laryngologists with apparently good results. The use of the arsenicals must depend on the patient's general condition, and if this is favorable, a trial dose of 0.45 to 0.6 grams may be given intravenously. Untoward reactions should be watched for, and if any are noted

[13] Moore, Irwin: Case of Syphilitic Disease of the Larynx, *Proc. Roy. Soc. of Med.*, 9:177, Sec. on Laryngology, 1915.

[14] Peacock, J. Raydon: Two Cases of Tracheotomy in Syphilitic Laryngitis, *J. Laryngol. and Otol.*, 48: 550-551, Aug., 1933.

[15] Harrison, W. J.: Gumma of the Larynx Necessitating Tracheotomy, *Brit. M. J.* 1:1292, June, 1914.

[16] Weinstein, Joseph: Syphilis of the Larynx, Case Report, *New York M. J.* 104:165, July, 1916.

the drug should be discontinued and milder treatment instituted. In most of the older individuals it is not wise to treat them with a negative serology as the goal, but only for relief of the local lesions, followed by a maintenance course of bismuth alternating with mercury, with frequent rest periods. The iodides should, as a rule, be discontinued when absorption of the lesion is complete, or if the patient develops iodism. Local treatment will depend on the nature of the lesion. In cases of ulceration the surface should be kept clean, if possible, by an alkaline spray or one containing hydrogen peroxide; Dobell's solution and sodium perborate may prove beneficial. The dysphagia may be relieved by the insufflation of orthoform powder, and the sucking of ice, and an adrenalin spray may aid in reducing the edema.[17]

The treatment of the resulting stenosis, if too marked to allow removal of the tracheotomy tube, consists of periodic dilatation of the larynx with metal dilators, increasing the size at weekly intervals, if possible. This form of dilatation may require from four months up to two years to obtain a sufficiently large passage to permit the removal of the tracheotomy tube. Other methods of dilatation may have to be resorted to, depending upon the type and degree of the stenosis.

The prognosis of tertiary laryngeal syphilis is favorable, provided the patient is seen early. Often the subjective symptoms are so mild that advanced stages may be reached before professional aid is requested. The infiltrations and gummata are prone to subside under treatment. Ulcers, once developed, heal only by scar formation and the resultant defects and sequelae often cause irreparable damage which may be a threat to life.

Conclusions:

(1) There is a definite decrease in the literature concerning syphilis of the larynx during the past fourteen years. This may be the result of the decrease in the number of cases of this disease seen in the past fourteen years.

(2) There are no pathognomonic signs or symptoms of tertiary syphilis of the larynx. The best aid to its diagnosis is to keep in mind the fact that the condition does still exist. A negative serology does not rule it out, and a positive serology does not prove the diagnosis.

(3) The pathology is the same as tertiary syphilis elsewhere in the body, but sudden laryngeal obstruction may prove disastrous.

(4) Adequate treatment should be given for the syphilis, but care should be exercised not to overtreat the patient. Tracheotomy should be considered if any signs of dyspnea are present. Chronic stenosis is treated as is laryngeal stenosis from other causes.

Case Report:

The patient, E.C.D., a white female, age fifty-seven, married, when first seen complained of hoarseness and wheezing but had no definite respiratory distress at the time. The hoarseness had been present for three months. She did not seek medical advice because she believed the hoarseness would disappear as had previous similar experiences during these three months. She had regained her natural voice for only a day or so at a time and then the hoarseness had recurred. About two weeks prior to the time she was first seen she began to wheeze during inspiration and this had become gradually worse. She had no other complaints.

As to her past history, she stated that she had measles, mumps, and chickenpox, as a child. Also, during childhood she had a fish bone removed from her throat. She had one miscarriage at five months about thirty years ago, no pregnancies before or after this; her menopause occurred some seven years ago. She had no bad habits and drank about one cup of coffee a day. She denied knowledge of any venereal infection, skin eruption, or swollen glands at any time. The patient had had no serious illnesses or operations. There was no history of any familial disease. Her husband was living and well except for a stricture of the urethra which he had had for many years. About five years ago during an acute attack of urinary retention an attempt to catheterize or sound him was made, and a perforation of the urethra was the result. On examination he had a urinary fistula into the perineal region from which urine flowed during micturition. After close questioning he denied having any penile lesions which could have been an initial luetic lesion. His serology report was negative from two laboratories.

Physical examination of the patient revealed a well-developed, well-nourished white female about the stated age. Her voice was only a hoarse whisper. During inspiration there was marked stridor and there was some expiratory wheezing. At this time there was no manifestation of any air hunger. There was no indrawing of the suprasternal or xiphoid regions, and the accessory muscles of respiration did not appear to be active. Her head was normal in size and shape except for an ovoid, firm, hard swelling over the right frontal region of the skull, which was roughly eight centimeters in diameter. It was not movable, and the overlying skin was not attached to the mass. There were no pulsations or bruit over the mass. She stated that she had had this intermittently for the past year. Examination of the ears showed both drum heads intact and a slight retraction of both. Both pupils reacted to light and accommodation. The fundi showed moderate arteriosclerotic changes in the vessels. Her nose was essentially negative except for a slight septal deviation to the right. Examination of the mouth revealed a complete upper denture and a few normal teeth remaining in the lower jaw. Tonsils were present, imbedded, and small. The pharyngeal mucosa was somewhat injected. Examination of the larynx with a mirror revealed a diffuse, red, smooth swelling in the region of the

[17] Jackson, Chevalier, and Coates, George M.: *The Nose, Throat, and Ear and Their Diseases*, W. B. Saunders Co., Philadelphia, 1930.

false vocal cords of both sides. It was more pronounced on the left, and there was also swelling over the left arytenoid cartilage. The left aryepiglottic fold was thickened, red, and smooth. The true vocal cords were obscured except for a small posterior portion of the right cord.

Examination of the chest showed normal respiratory excursions, no dullness to percussion. Auscultation revealed a wheezing, especially pronounced on inspiration, which could be heard over all the lung fields. No rales were heard. The heart was normal in size and shape to percussion, and the heart sounds were normal to auscultation. Her blood pressure was 190 systolic and 104 diastolic. The abdomen revealed no tenderness or masses.

On examination of the extremities, there were numerous small, firm, epitrochlear nodes bilaterally; they seemed to be about five millimeters in diameter. The lower extremities were negative. No periosteal thickening over the tibia could be found.

The laboratory work on the day of admission was as follows:

Red Blood Count	4,630,000
Hemoglobin	85%
White Blood Count	8,300
Neutrophils	61%
Lymphocytes	36%

The x-ray report was as follows:

"Anterior-posterior and lateral views of the neck and soft tissues. In the lateral view a soft tissue tumor partially obliterates the air space in the region of the larynx. The tumor lies more on the left side in the anterior-posterior view. In the film of the chest the lung fields appear clear. Heart shadow is within normal limits. Supra-cardiac shadow is not enlarged.

"Films of the upper and lower extremities reveal no diagnostic abnormality. Marked calcification of the vessels in the leg. Tangential films of the skull reveal periosteal proliferation and gross irregularity of the cortical surface of the right frontal region. Appearance suggests syphilitic periostitis."

The day following her admission to the hospital, after she returned from the x-ray laboratory, she began to develop mild respiratory distress. She was reasonably comfortable if she remained absolutely quiet, but the least exertion in bed produced air hunger. No medication was given. The following morning it was thought advisable to perform a tracheotomy before it was required as an emergency measure and to take a biopsy under direct vision through a laryngoscope. The tracheotomy was performed under local anesthesia through the second and third tracheal rings, and relief of the dyspnea was immediately noted. An adult laryngoscope was next inserted, and a small piece of tissue was removed from the larynx for microscopic examination. The patient was returned to the ward in good condition, and a moist gauze square was kept in place over the tracheotomy tube opening to moisten the inspired air. The patient's general condition continued to improve, and only supportive treatment was given at this time.

The following report was received concerning the biopsy specimen:

"This is a marked chronic inflammation in which lues cannot be excluded. It is granulomatous in nature but it is believed that tuberculosis and actinomycosis can be excluded at least as far as these sections are concerned. The possibility of an inflammatory region peripheral to an ulcerating carcinoma cannot be excluded. Diagnosis: Chronic inflammation."

A report of the blood Wassermann from two laboratories was 3 plus. A lumbar puncture was performed, and the dynamics were normal. The laboratory report of the spinal fluid showed no cells, 42 mg. per cent of protein, no globulin, and 60 mg. per cent of sugar. The spinal fluid Wassermann was negative, and the colloidal test was negative.

Six days after the first biopsy, a second was taken from the larynx through the laryngoscope, and the microscopic report was essentially the same as the previous one.

The dermatologist's consultation was as follows:

"No doubt that this is a very old, untreated case of syphilis. The frontal lesion is clinically, as well as radiologically, typical of syphilis.

"Would suggest to start the treatment with potassium iodide (saturated solution ten drops three times a day and reduce in case of toxic symptoms). This ought to be followed by bismuth or mercury. The arsphenamines should not be used unless the potassium iodide fails, which is very unlikely, and a thorough examination of the heart and aorta shows no involvement."

The patient was started on the suggested dose of potassium iodide and this medication was continued during her stay in the hospital. Eighteen days after starting potassium iodide she was given 4 cubic centimeters of iodobismuthate quinine intramuscularly in the hip, this being followed the next day by a similar injection of the same preparation.

The patient continued to improve generally and was able to talk and breathe fairly comfortably when placing her finger over the opening in the tracheotomy tube. Three weeks following the tracheotomy a cork was placed in the tracheotomy tube, there was no respiratory embarrassment, and the voice had markedly improved. The tracheotomy tube was removed the following day, and there was no distress in breathing. The tracheotomy wound healed quickly and the patient was discharged from the hospital thirty-three days after admission. At this time her larynx, when examined by mirror, revealed great reduction in the lesion; both vocal cords were visualized and appeared to move freely. There was still a slight huskiness to the voice, and some thickening remained over the left arytenoid cartilage and left aryepiglottic fold. There was also a marked reduction in the size of the frontal periostitic lesion.

The patient was instructed to continue the potas-

sium iodide at home. The patient was seen weekly for about six weeks and given 4 cubic centimeters of iodobismuthate quinine at each visit. She continued the potassium iodide for about three months after her release from the hospital.

The patient was last seen about five months after her initial visit. At this time examination of the larynx revealed only a very slight raggedness of the left aryepiglottic fold. The voice was normal, and the frontal periostitis had entirely disappeared.

Comment:

This case illustrates that tertiary syphilis of the larynx, if properly treated before ulceration had developed, will undergo nearly complete resolution and that the laryngeal structures will return to normal in appearance and function. It has also been demonstrated by this case that dyspnea as a result of space-taking lesions of this type may be immediately relieved by tracheotomy.

TREATMENT OF DIABETIC COMA*

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DIABETIC coma is an acute medical emergency to be classed with acute myocardial infarction, a ruptured viscus, or an acute appendicitis.

We are all familiar with the appearance of a patient with marked dehydration, deep Kussmaul respiration, and complete unconsciousness. This is the picture of severe diabetic coma, and with our present knowledge of this condition there is no excuse for a patient to present this type of picture.

To satisfy the criteria for diagnosis of diabetic coma the patient must have a hyperglycemia, ketonuria, and changes in the blood electrolytes affecting the acid-base balance. The latter is determined in most laboratories by the carbon-dioxide combining power of the blood. The level of carbon-dioxide diagnostic of coma varies with authorities. Joslin suggests a level of twenty volume per cent as the dividing line, since prior to insulin most of his patients died with a carbon-dioxide of twenty or below while those with carbon-dioxide of twenty or above usually survived. Other authorities contend thirty should be the dividing line since many patients succumb in acidosis with readings between twenty and thirty.

It is important to know a patient may fulfill all the diagnostic criteria of diabetic coma and still apparently maintain mental faculties enough to answer questions intelligently. Curiously, after improvement, they will remember nothing, but to all appearances at the time they were perfectly rational. It is therefore important to suspect coma from our clinical findings, confirm it by laboratory tests, and treat it accordingly before the patient is moribund.

A better index to measure the degree of acidosis and also a better index for the diagnosis of diabetic coma would be a determination of the total ketone body content of the blood. This would give direct reading of the agents producing coma. Unfortunately, this test is not available in all hospital laboratories but Mirsky has given a splendid correlation between clinical symptoms and the total ketone bodies in the blood stream.[1] He found that with ketone body levels of thirty-five milligrams per cent or below, the patient had no symptoms. With readings of thirty-five to seventy milligrams per cent the symptoms of polyuria, polydipsia, nausea, vomiting, and abdominal pain became progressively more severe as the ketone bodies increased. He was forced to stop the experiment at the level of seventy milligrams per cent because it was obvious the patient would have passed into coma.

Diabetic coma is produced by the lack of insulin, both endogenous and exogenous, infection, or food indiscretion. A combination of any of the three may be the initiating cause of coma. Of all the factors the most common cause is the lack of insulin.

Insulin is antiketogenic in action for it produces glycogen deposition in the liver. With the lack of insulin glycogen storage is diminished and the remaining glycogen reserve falls to a low level. It is this situation which produces the abnormal ketone body formation. It is an established fact that ketone bodies are normally formed by metabolism of fats in the liver and these ketone bodies are normally utilized as energy by the body tissues which oxidize them to carbon dioxide and water.[2] It is Mirsky's thought that both glycogen and fat are acted upon by the same enzyme in the liver and when glycogen is no longer available, as in dia-

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[1] Mirsky, I. Arthur, et al.: The Role of Excessive Carbohydrate Intake in Etiology of Diabetic Coma, *J. Clin. Endocrin.*, 1: 307, 1941.

[2] Best & Taylor, *Physiological Basis of Medical Practice*, Third Edition. Baltimore, Williams & Wilkins.

betic coma, the enzyme action is then upon the fats with a resultant acceleration in the production of ketone bodies.[3]

As the ketone body production is increased above tissue utilization the patient begins to show clinical symptoms and it is the presence of the ketone bodies which produces all the serious changes. It is the action of the ketone bodies on the central nervous system which brings about the Kussmaul respiration, the nausea and vomiting, and the unconsciousness. These are readily understood but there is a change produced by the presence of ketone bodies which is often overlooked and may be disastrous. Ketonuria plus glycosuria produces an accelerated excretion of chloride through the urine.[4] It is the chloride loss, plus dehydration, with the resultant change in intracellular metabolism, which produces tissue anoxemia with production of peripheral circulatory collapse. This is a serious consequence of coma and accounts for many sudden deaths in patients who are otherwise responding favorably.

In the treatment of coma our aims are to stop the formation of ketone bodies by restoring normal carbohydrate and fat metabolism, restore lost body fluids, maintain a normal circulation, and combat infection. In carrying out these measures we wish to do so in such a manner that the process producing coma will be reversed, our patient unharmed, and the laboratory tests used to show effectiveness of treatment undisturbed.

Before treatment is instituted a thorough physical examination is absolutely essential to seek the source of any type of infection which may be the initiating cause. It goes without saying that all chemotherapeutic agents have been of inestimable value in the treatment of diabetic coma precipitated by infection.

Since coma is due to a lack of insulin, which is antiketogenic, our next step is to give insulin as rapidly as possible and at times in heroic dosages. The amount of insulin to be given will, of course, depend upon the severity of each individual case, but coma is no place to depend upon homeopathic doses of insulin. Root has drawn attention to the initial blood sugar reading in milligrams as an index to the amount of insulin to be given in units in the first twenty-four hours.[5] It is the use of adequate amounts of insulin within the first three hours which has lowered Joslin's mortality rate in completely unconscious patients from 35 per cent to 10 per cent. The average amount of insulin in cases reported by Root was 212 units within the first three hours. It is a good plan to estimate the total amount of insulin to be required in the first three hours, which is usually between 175 and 250 units, and give one-third to one-half as the initial dose, and give the remainder at one-half-hour intervals, depending upon blood sugar and urine sugar observations along the way. In this connection it must be stressed that hypoglycemia produced in the treatment of diabetic coma should be welcomed instead of feared, for the condition has been changed from one which may be irreversible to one which will respond to treatment in a matter of minutes.

The next procedure is to correct the dehydration and replace the lost chlorides. This can be accomplished by giving intravenous normal saline in adequate amounts. The average case will require 2,500 to 5,000 cc., given at the rate of 15-20 cc. per minute. Of course, this brings up the ever present argument as to whether intravenous glucose, sodium lactate, or sodium bicarbonate should be used in the treatment of coma.

We must remember we are already dealing with a situation in which there is an adequate amount of glucose available but it can not be metabolized properly. In the Joslin group, when a coma death is reported by someone from out of town, someone in the group immediately asks, "How much glucose did the patient receive intravenously?" Glucose intravenously in diabetic coma adds insult to injury. First of all, it will paralyze the already overburdened Islands of Langerhans so that they cannot produce endogenous insulin. Secondly, should the patient survive the coma after glucose has been given, the Islands may be damaged to such a degree that a mild diabetic prior to this may become a severe one afterwards. Root and Carpenter have shown that the most that can be hoped for in coma is the combustion of from five to ten grams of carbohydrate in the first two hours. Since this much carbohydrate is already available, why add from fifty to one hundred grams of glucose intravenously which cannot be metabolized but will only act to increase the glycosuria, loss of body fluids, and with it the loss of more chloride which we are trying so desperately to conserve? Lastly, the blood sugar reading will be destroyed as an index to the amount of endogenous glucose not yet metabolized and thereby destroying this very useful test to show progress of treatment.

Sodium lactate and sodium bicarbonate are not antiketogenic in action, as is insulin, but act only as neutralizing agents during the time of administration and for a short period following administration. It is true both agents will increase the CO_2 combining power, reduce the Kussmaul respiration, reduce the restlessness of the individual, and from all appearances help a desperate situation. We must remember this improvement is only temporary since neither agent has prevented the formation of ketone bodies. We are given a false sense of security, seeing the patient responding so well, only to find after their action is spent our patient has returned to the former state of acidosis

[3] Mirsky, I. Arthur: The Etiology of Diabetic Acidosis, *J. A. M. A.* 118: No. IX, (Feb. 28) 1942.

[4] Gabrilove, J. L.: Chloride Excretion During Glycosuria in Patients with Diabetes, *J. Clin. Invest.*, 25: 256, (Mar.) 1946.

[5] Root, H. F.: The Use of Insulin and the Abuse of Glucose in Treatment of Diabetic Coma, *J. A. M. A.*, 127: 10, (Mar.) 1945.

and much valuable time has been lost in the treatment. It is well to remember the patient may still die in diabetic coma even though the CO_2 combining power has been raised above coma levels by these agents. These agents also destroy as a yardstick the CO_2 combining power, the total acetone body content of the blood, and a number of the physical signs which are all necessary as indices to our treatment.

It must also be stressed that replacement of fluids and chlorides by the use of normal saline will not in all instances prevent or alleviate peripheral circulatory collapse even though this condition is produced by the loss of these agents.[6] The use of oxygen and replacement of colloidal matter by whole blood transfusions and plasma transfusions must not be neglected in the treatment of shock. The use of elastic bandages to the extremities and shock position may be life-saving until other measures can be instituted.

After all the above procedures have been instituted, and it is assured from laboratory and clinical findings that the patient is doing well, a gastric lavage must be considered. It is common knowledge that these patients are prone to have capillary hemorrhages in the stomach, with accumulation of old blood, and at times tremendous gastric distention. Some authorities state lavage should not be done because it further depletes the chlorides. If done at the proper time, it is without danger and relieves the patient of a great deal of distress, and prepares the patient so oral feedings may be instituted early.

When the patient is responsive and comfortable, fluids and foods may be started by mouth. Fluids must be given slowly and, if tolerated, followed by soft foods, with the idea of administering fifty to sixty grams of carbohydrate within the next eight to ten hours.

Even after the patient is out of coma and appears to be doing well, care must be exercised to keep the patient from returning to acidosis. This is best accomplished by giving adequate amounts of a slow acting insulin, preferably protamine zinc insulin, the average case requiring thirty to forty units.

At times conditions arise which may be problems in treatment. A patient may have a normal blood sugar, continue to have ketonuria, and show alterations in CO_2 almost to coma level. This condition must be differentiated from diabetic coma and is due to starvation acidosis from glycogen depletion. These patients will respond rapidly to administration of carbohydrate and is the only condition in treatment of coma besides hypoglycemia where the administration of intravenous glucose is justified. If the blood chemistry shows improvement, and the patient remains unconscious, search for some central nervous system pathology. Remember, meningitis can simulate as well as precipitate diabetic coma.

Anuria developing during coma is a distressing affair. In the absence of other kidney pathology it may be due to an extreme loss of blood chlorides and will respond well to intravenous use of hypertonic salt solution.

Prevention of coma is much more simple than the treatment of coma. Diabetic patients are eager for knowledge of their disease and should be taught practical methods to care for themselves. They should be taught that in the presence of infection, even though they are unable to eat, their insulin requirement will increase. It is so simple to teach the patient to examine the urine for sugar, and to take additional insulin as required throughout their illness. Too often we all hear, "Well, doctor, I couldn't eat and I didn't think I required insulin." This bit of misinformation probably accounts for more cases of diabetic coma than anything else.

In closing, I wish to stress the importance of constant personal attention while treating diabetic coma. It cannot be treated by predetermined orders to be carried out by the nursing staff, nor can it be treated by telephone, for changes can take place so rapidly that a patient apparently recovering can suddenly change and become moribund.

[6] Danowskie, T. S., et al.: Salt Depletion, Peripheral Vascular Collapse, and the Treatment of Diabetic Acidosis, *Yale J. Biol. & Med.*, 18: 405-417, (May) 1946.

LEIOMYOMA OF THE STOMACH; A CASE REPORT*

C. O. Almquist, M.D.

GARY

LEIOMYOMA of the stomach is comparatively rare and is frequently diagnosed as bleeding peptic ulcer or as cancer of the stomach. A number of cases have bled to death while others have come to operation only because of severe hematemesis or melena; these patients enter the hospital with very marked anemia. Some of the patients who do not have hemorrhage enter because they have obstruction of the pylorus or cardia, for which they seek relief. The duration of the malady may vary from one to twenty years. The bleeding and other symptoms may be acute or there may be repeated attacks; usually, however, there are repeated hemorrhages before the patient presents himself for treatment. Those who have obstruction naturally present themselves earlier, usually during the first attack.

The physical examination gives very little information unless the mass is large. Only the large tumors can be palpated. The laboratory tests are normal except when bleeding is present, then the benzidine test is positive. The red blood count is not low until some time after severe hemorrhage. There may be some loss of weight but weakness and dizziness is a common complaint, especially in those who have bled. Roentgenograms are the most helpful aid in the diagnosis; they usually show a filling defect which is most common in the pars media of the stomach. Davidson[1] describes x-ray signs of gastric leiomyoma as:

"1. Regular filling defect, usually between intact curvatures (particularly with submucous growths).

"2. Signs of external pressure (particularly pedunculated growths).

"3. Abnormally devious but intact rugae (submucous growths).

"4. Crater formation (ulceration has taken place).

"5. Block in peristalsis (mural types).

"6. Filling defects in the organs adjoining (notably in duodenum in the intragastric pedunculated growths).

"7. Obstruction at cardia and pylorus."

Christopher, Benjamin and Sauer[2] reported a case of leiomyoma malignum in a girl eleven years of age. She had repeated vomiting spells and a tumor could be felt in the epigastrium. X-ray revealed a tumor mass encroaching on the duodenal bulb, antrum, and the body of the stomach from the lesser curvature. A Hofmeister-Polya gastric resection was done. The girl was seen twenty-five months after the operation. She had gained twenty-one pounds and was feeling well. Authors, however, gave guarded prognosis because of the character of the cells in the tumor. Microscopic picture of the tumor showed anaplastic mesenchymal cells with mitotic figures in the prophase. These authors feel that this is a case of gastric leiomyoma which has characteristics of malignancy but the picture does not conform histologically with that of sarcoma. Pure leiomyoma was found six times during the period from January, 1936, to November, 1940.

They classify neoplasms of the smooth muscle of the stomach as follows:

"1. Benign leiomyoma.
"2. Leiomyoma malignum.
"3. Metastasizing leiomyoma.
"4. Leiomyosarcoma."

In 1936 Conway[3] collected reports of fifty-six cases of leiomyoma of the stomach and added two cases of his own; distribution as to sex was equal. He found that the symptoms were:

(1) Pain in the upper part of the abdomen, and vomiting from small tumors at or near the pylorus; in only two cases were the tumors palpable; these were 8 cm. x 6 cm. and 5 cm. x 7 cm., respectively. The symptoms were those produced by pyloric obstruction.

(2) Symptoms of partial gastric obstruction from large leiomyoma occurring in the fundus of the stomach.

(3) Cases of small leiomyoma at a distance from the pylorus and manifesting itself by severe gastro-intestinal hemorrhage.

(4) Small leiomyoma which is asymptomatic.

His two new cases were described in detail, one in which operation was imperative because of gastric hemorrhage, the other case in which a small tumor at the pylorus caused obstruction that was relieved by resection of the tumor. Both patients made uneventful recovery.

Eusterman and Senty[4] reported twenty-seven cases of benign tumors of the stomach discovered at operation in a period during which 2,168 malig-

* Presented before the Section on Surgery of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

[1] Davidson, P. B.: Leiomyoma of the Stomach, Clinical Aspects, *Tr. Am. Gastro-Ent. Assn.*, 33: 157-158, 1931.

[2] Christopher, F.; Benjamin, E. L.; and Sauer, L. W.: Leiomyoma Malignum of the Stomach, *Surg.*, 10: 381-386, (Sept.) 1941.

[3] Conway, J. H.: Leiomyoma of the Stomach, *Arch. Surg.*, 33: 792-807, (Nov.) 1936.

[4] Eusterman, G. B., and Senty, E. G.: Benign Tumors of the Stomach, *Surg., Gyn., Ob.*, 34: 5-15, (Jan.) 1922.

nant gastric new growths were found at operation. This is a ratio of 78 to 1; 1.3 per cent of all gastric tumors are benign, 11.1 per cent of all benign tumors of the stomach are leiomyoma.

Nadeau and McCarty[5] reported a study of gastric tumors over a period of eight years. They found 1.2 per cent were benign.

Lindquist and Mock[6] reported a case of a sixty-one-year-old steel worker. His only symptom was slight tenderness in the epigastrium; laboratory findings normal, except positive benzidine. X-ray showed a definite filling defect on the greater curvature of the stomach. There was little interference with peristalsis and little distortion of the rugae. Therefore, roentgen diagnosis was benign tumor of the stomach. However, later x-ray showed filling defect on the greater curvature of the pars media. The one edge seemed smooth and the other was irregular, so the tumor was considered to have evidence of malignancy. At operation a pedunculated rounded tumor was found attached to the mucosa. A crater-like ulcer was present on the dome of the tumor, from which bleeding had occurred. Local excision of the tumor was done. The pathological report was leiomyoma of the stomach.

Melnick[7] states that sometimes these cases may be thought to be ruptured esophageal varices. His case had been seen elsewhere due to severe anemia, R.B.C. 450,000, hemoglobin 18 per cent. Patient left one hospital to enter another hospital one week later, in extremis. He was given blood transfusions to bring blood count up to 3,450,000 and hemoglobin 55 per cent. He left the hospital against advice, but returned nineteen days later, moribund. He died one week after admission.

Autopsy revealed ulcerated leiomyoma of the stomach metastasizing to the liver and severe secondary anemia. This case bled to death from ulcerated tumor of the stomach.

Down[8] presented a woman sixty-six years of age who had repeated gastric hemorrhages over a period of twenty years. These bleeding spells finally became so severe that she remained weak for longer periods after each episode. When seen at the clinic she was fluoroscoped. This examination revealed a polyp 3 cm. in diameter on the posterior wall of the stomach. The diagnosis of a benign tumor with secondary anemia was made. Operation was advised and performed. A tumor was found growing on the peritoneal surface in such a manner that a portion of it was extragastric. The final diagnosis was leiomyoma of the stomach. Patient made rapid recovery.

Meyer and Rosi[9] reported a case which mimicked a bleeding ulcer. He had been on medical therapy but became weak and dizzy. X-ray report showed a filling defect in the pars media that was smooth and round. Alterations of the rugous folds were noted around the tumor. There was no delay in emptying time. Roentgen opinion was benign tumor of the stomach. Laporotomy revealed the stomach freely movable; in pars pylorica there was a moderately firm, circumscribed tumor. Histologically this new growth was a benign smooth muscle tumor or leiomyoma. These authors also reported leiomyoma the size of a grapefruit in another case. Both cases made complete recovery.

David Whyte[10] feels that most innocent tumors of the stomach develop in the pyloric segment and project into the cavity. His first case had a tumor in the cardiac portion high up on the greater curvature, which projected away from the stomach; the second tumor occurred on the cardiac portion of the stomach and projected into the stomach. The first was a laborer who had symptoms for five and one-half years, finally vomited blood, and became very weak. He was transfused and later operated. He had a dark red, circumscribed, fluctuant tumor, arising from the greater curvature of the stomach, high up, and extending into the left border of the gastrocolic omentum. Local excision of the mass was done, with recovery. Pathological report showed no malignancy but leiomyoma. His other case was a clerk who felt nauseated and began to sweat while at work. Forced vomiting showed blood. A partial gastrectomy was done. This tumor projected into the stomach. Another leiomyoma was found histologically.

Eckhoff[11] removed a tumor that was found to be a leiomyoma. His patient was a woman, twenty-five years of age, whose symptoms were discomfort in the abdomen which culminated in her vomiting a pint of blood. A filling defect in the mid-gastric area was demonstrated by x-ray. At operation a large, round, mobile lump, about three inches in diameter, was found. It was easily movable in the lumen and attached to a stalk in the lesser curvature of the stomach in its upper half. A deep ulcer was felt on the opposite pole of the tumor. He states that during the decade 1933 to 1942 the clinical reports at Guy's Hospital contained only two examples of leiomyoma.

Hartman and Camp[12] reported a case of smooth muscle tumor associated with a malignant gastric polyp. Levy and Horn[13] presented a case of gastric leiomyoma with ulceration.

Willis[14] described a case of gastric leiomyoma that was found at autopsy. The diagnosis offered

[5] Nadeau, O., and MacCarty, W. C.: Benign Neoplasms of the Stomach, *Tr. Clin. Path. Soc.*, X: 51-52, 1916.

[6] Lindquist, J. L., and Mock, H. E.: Gastric Leiomyoma, *Northwest Med.*, 36: 42-44, (Feb.) 1937.

[7] Melnick, P. J.: Metastasizing Leiomyoma of the Stomach, *Am. J. Cancer*, 16: 890-902, (July) 1932.

[8] Down, H. I.: Leiomyoma of the Stomach Associated With Gastric Hemorrhage, *Proc. Staff Meetings Mayo Clin.*, 5: 363 (Dec. 17) 1930.

[9] Meyer, K. A., and Rosi, P. A.: Leiomyoma of Stomach, *Surg. Clinics of N. A.*, 13: 1245-1249 (Oct.) 1933.

[10] Whyte, D.: Leiomyoma, Two Cases, *Australia & New Zealand J. Surg.*, 10: 183-188, (Oct.) 1940.

[11] Eckhoff, N. L.: Leiomyoma of Stomach, Case, *Guy's Hosp. Rep.*, 91: 153-156, 1942.

[12] Hartman, H. R., and Camp, J. D.: Leiomyoma of Stomach Associated with Malignant Polyp, *Minn. Med.*, 20: 387-389, (June) 1937.

[13] Levy, S. I., and Horn, J. S.: Leiomyoma of Stomach with Ulceration, *Brit. M. J.*, 2: 580, (Oct. 25) 1941.

[14] Willis: Leiomyoma of the Stomach, *M. J. Australia*, 1: 746-747, (June 7) 1930.

was cancer of colon or possibly an unusual primary splenomegaly.

Halperin[15] reported a case of a fifty-eight-year-old housewife who was operated upon, with diagnosis of cancer of the stomach. She had pain in the epigastrium, nausea, and vomited coffee ground material. Postoperative diagnosis was leiomyoma on the posterior wall of the stomach. The stomach was resected with uneventful recovery.

The only case reported from the medical college of Virginia was one of gastric hemorrhage which was operated and found to be leiomyoma. According to Bloom and Williams[16] this was the only case of leiomyoma over a span of fifteen years.

The studies of Rienerts[17] would indicate that leiomyomas of the stomach are more common than is generally thought. In the first one hundred consecutive postmortem examinations at the Mayo Clinic in 1928, twenty-one leiomyomas were found in sixteen stomachs. A second group of one hundred stomachs was found to contain twenty-two leiomyomas in sixteen stomachs. Thirty-four additional leiomyomas in thirty stomachs were found in a third group of unmentioned size. In all, seventy-seven leiomyomas were found in sixty-two stomachs. In fifty cases there was a single tumor; in nine cases two tumors, and in three cases three tumors. There were forty-three males and nineteen females, average age 59.17 years. There were thirty cases of leiomyoma reported between 1930 and 1945, in addition to those reported by Conway.

Case Report of a Leiomyoma of the Stomach

A housewife, seventy-six years of age, complained of nausea and vomiting, with distress over the epigastrium. She had never had any previous trouble except a feeling of pulsation in her stomach in 1918. She had no further distress until December 4, 1943. At this time she began vomiting and after December 5 she could retain nothing on her stomach. This continued until December 10, when she was sent to the hospital.

Physical examination upon entrance revealed an emaciated white female, who was very weak and dehydrated. She weighed eighty-five pounds; head and neck essentially negative except for emaciation; pupils equal and reacted to light and accommodation; chest, both sides equal in expansion, breath sounds were normal; heart normal in size, no murmurs; B.P. 160/100; abdomen distended and tender on pressure over left epigastrium, no tumor could be palpated; reflexes were physiological; the skin was very dry.

Roentgenological examination revealed a hypotonic colon; an oval shadow in the right upper quadrant resembled a gallstone. The proximal half of the stomach filled well but none of it passed into the distal half for a rather long time, due to spasm in this region. There was some regurgitation through the cardia into esophagus. After a rather long interval, the distal half of the stomach filled in a very irregular fashion and showed an extreme mottling. Peristalsis passed very poorly through this region. The duodenal bulb, never well visualized, was either attached by adhesions or tumor infiltration into the stomach. The entire appearance was rather atypical, most likely due to carcinoma of the stomach. Re-examination two and one-half hours later still showed a little retention of barium in the stomach, indicating marked delay in gastric motility.

The patient was prepared for surgery. She was given fluids and two blood transfusions before operation. She was operated December 30, 1943, or three weeks after admittance. An upper midline incision was made, stomach exposed and palpated. A tumor mass could be palpated in pars media. An anterior Polya gastrectomy was done, removing about two-thirds of the stomach; 400 cc. citrated blood was given postoperatively. She made a speedy recovery and left the hospital seventeen days after operation. Patient was last seen September 6, 1946, aged 80, and in good health. She weighed ninety-seven pounds and was able to eat everything, without distress. Laboratory report: R.B.C. 4,800,000; W.B.C. 4,800; hemoglobin 95 per cent; urine negative.

Pathological report: "Gross specimen consists of a segment of the stomach 7 cm. x 10 cm.; near one end is a broad hillock with a broad base; a pedunculated tumor mass measuring 3 cm. x 3 cm. x 3 cm., which is extremely smooth and only at top mucosa appears intact, partially ulcerated. Serial section shows tumor to be hemorrhagic and located in submucosal layers of infiltrated muscle wall of the stomach, which in its thickest portion measures 0.7 cm.

"Microscopic: two blocks show mucosa of the stomach is intact and it appears that the underlying tumor has grown into the mucosa and here muscularis mucosa is intact. At the edge there is local invasion of epithelial cells with normal polarized nuclei. A band of lymphocytes is seen just beneath mucosa and here much hyalanized fibrous connective collagen-rich tissue is present. Other areas smooth muscle intertwine with connective tissue resembling leiomyoma of the uterus. Hyalinized areas suggest slow growth. Large blood vessels lie adjacent to muscularis. Focal recent and older hemorrhages are seen throughout. The smooth muscle appears normal except for distortion and interlacing. In some small areas are unrecognizable cells with vacuolated cytoplasm but here mitosis and anaplasia are not recognized. In other four blocks tissues are torn, focal areas are very vascular, appear like capillary hemangiomata.

[15] Halperin, P. H.: Leiomyoma of the Stomach, a Case, *J. Mo. Med. Assn.*, 38: 235-237, (July) 1941.

[16] Bloom, N., and Williams, C.: Leiomyoma of Stomach, Case, *Va. Med. Monthly*, 69: 627-629, (Nov.) 1942.

[17] Reinerts, J. H.: Leiomyoma, Frequency and Pathologic Aspects of Gastric Leiomyomas, *Proc. Staff Meet. Mayo Clin.*, 5: 364-366, (Dec. 17) 1930.

Many areas show recent hemorrhages and many cells in this area resemble plasma cells with chromatin evenly distributed in nuclei. They resemble hemangio-endothelioma. Pathological diagnosis: Benign leiomyoma with angiomatous portions. Primary in the stomach."

After a review of the literature I feel that leiomyoma is a surgical condition of the stomach. This condition was cured by resection of the tumor or part of the stomach in 90 per cent of the cases reviewed. In two of the cases that were reported malignant good results were obtained by surgery although prognosis was guarded. Both of these patients were alive at time of the author's report. One patient bled to death who could have been saved by operation. There was no case of surgical failure.

In conclusion I would consider that: x-ray is the most valuable aid in diagnosis; repeated attacks of hematemesis are the most frequent symptoms; obstruction with vomiting occurred in some of the others; a small number was asymptomatic; surgical removal of tumor is very successful and complete recovery can be expected unless associated with malignancy.

Summary

(1) One additional proved case of leiomyoma is reported.

(2) Surgical removal was successful with complete recovery from any distress.

(3) The peculiar filling defect demonstrated by x-ray is suggestive of benign tumor.

(4) Laboratory findings are usually normal.

(5) Some cases have bled to death because the true condition was not recognized.

(6) Leiomyomata are more frequent than we have thought them to be. They may occur at any age; youngest in these reports was eleven-year-old girl, and the oldest case was eighty years of age; usually, however, they occur during or after middle age. It is also interesting to note that the malignant tumor was found in the youngest and a benign tumor found in the oldest.

(7) The reviewed reports show how frequently benign tumors of the stomach are thought to be bleeding ulcers or malignancy. One case was diagnosed as esophageal varices.

(8) Every case of severe gastric hemorrhage or of gastric obstruction should be explored, after proper preparation.

IMPORTANT NOTICE

Chapter 254, of the 1947 Acts of the General Assembly of Indiana, requires: That every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the Healing Art in any form or manner, granted by the Board of Medical Registration and Examination of Indiana, shall be required to register with said Board, during the month of July and not later than the last day of August, immediately following the effective date of this Act, which registration shall be for the period ending June 30, 1948, and shall, annually thereafter, on or before August 31 of each year, be required to register with said Board.

Each applicant for registration shall remit with his application the sum of Five ($5.00) Dollars as the annual registration fee if he resides within the boundaries of the State of Indiana; and if residing outside the boundaries of the State of Indiana, shall remit the sum of Ten ($10.00) Dollars as the annual registration fee; Provided, that no registration or fee for registration shall be required of any holder of a certificate on or before the month of July of the year following the year within which such certificate was issued.

Failure to comply with provisions of this Act shall operate automatically to cancel his/her certificate, and any license issued thereunder, and continued practice after cancellation of the certificate and license issued thereunder shall be considered as practicing without license. A certificate cancelled for failure to register may be reinstated by said Board upon submission of the applicant's last registration certificate together with current and delinquent fees, and a penalty in the sum of Ten ($10.00) Dollars.

If you have not already received an application blank from the Board of Medical Registration and Examination of Indiana, 416 K. of P. Building, Indianapolis 4, Indiana, for use in making annual registration of your license to practice, please write to the board and ask that one be mailed to you.

The deadline for paying the $5.00 registration fee ($10.00 non-resident) without penalty is August 31.

BLOOD SUBSTITUTES AND BLOOD TRANSFUSION

William Henry Gordon, M.D.

DETROIT, MICHIGAN

Blood Transfusion—Historical

ALTHOUGH blood transfusion, as a routine, everyday occurrence, was first born in the early, anxious days of World War I, the possibilities of this measure in medical therapeusis were visualized, proposed, and possibly attended by clinicians, long before the beginning of the Christian era.

The limning of ancient manuscripts, as well as a survey of folklore, mythologies, and legends would convince the most skeptical of that fact: Aam, leader of the Persian Armies in the reign of King Ben-Adad, was stricken with leprosy. The king's physician had allegedly withdrawn blood from Aam's veins and thereon introduced into his depleted blood stream the blood of a healthy male. Pliny and Celsus reported the headlong rush of the Roman populace into the gladiatorial arena towards the end of the day, in order to imbibe the blood of dying gladiators so that they might be rejuvenated and made whole again. And in other writings of that same era the value of blood in the treatment of various and sundry diseases was emphasized. In the Section of Heda, in the Book of Ovid, an aging, unhealthy man was exsanguinated and transfused shortly thereafter with the blood of a youth; in this instance a vein in the neck was allegedly utilized for the transfusion. In 1492, Pope Innocent VIII was treated with blood for a serious illness; but in that case the blood was believed to have been administered by mouth. Whether or not the intravenous route was actually attempted in those ancient days must of necessity remain a matter of conjecure.

Hieroymus Cardanus and Magnus Pegelius (1505-1576), however, did suggest the transfusion of blood from the blood vessels of one person to those of another, while Andreas Libavius, in 1615, was the first to outline with some practicability the actual technique of blood transfusion. He proposed that the blood vessel of the donor be connected with a blood vessel of the recipient by small silver tubes.

But despite legend, despite these and a thousand other theoretical proposals, the fact remains that latter-day scientific blood transfusion had its incepton in Harvey's discovery of the circulation, in 1616, and his monograph on the subject which was published in 1628. From that time until the time of World War I progress toward the goal of safe transfusion of blood from one person to another was rapid, in terms of medical years.

Our heritage, so far as modern blood transfusion is concerned, could not be credited to any one investigator or to any one group, but rather to the collective endowment of many indefatigable and brilliant minds. In the field of animal experimentation Richard Lower was the first to exsanguinate a dog completely through the carotid artery and yet keep the animal alive by a coincident sanguinating transfusion from other dogs. In 1667 Denys and Emmerez successfully accomplished the first of many intravenous transfusions, wherein nine ounces of fresh lamb's blood was administered to a young man. But in one transfusion of a similar nature at a later date they reported that the patient had shortly thereafter passed urine ". . . as dark as soot." The experience of Lower and King in that same year was considered worthy of comment. The same type of transfusion, nine ounces of lamb's blood, was administered intravenously to a patient suffering from lues. Coincident with lues, the subject was in the throes of mania at the time of transfusion. Said mania was reported as having been definitely alleviated by the first transfusion. A second one was therefore administered, but on that occasion the subject's arm had suddenly appeared hot and angry, pulse had been elevated, hyperhidrosis of the forehead had been marked, he had complained of "pain in the kidneys and sickness at the stomach." The following day the urine had appeared very black. A third transfusion was attempted; it resulted in fatal shock. Whether or not this accident and several others of the same nature had any bearing on developments, the fact remained that in the following year, 1668, blood transfusion in France was strictly prohibited except by special permit from the Faculty of Medicine of Paris. And by 1678, English Parliament had arrived at the same conclusion; in net, it had prohibited blood transfusion throughout the realm. Through these and other similar governmental decrees, scientific advance in the field of blood transfusion was delayed and checkmated for more than a hundred years.

By 1805, however, and continuing into the present, progress was rapid and inexorable. Bischoff, in 1805, was the first to administer defibrinated human blood into the vein of a recipient. The blood for this purpose had been collected, whipped, and filtered through gauze before injection. James Blundell, 1818, transfused whole blood into a patient with the aid of a large bowl for the donor's blood which he had connected with a syringe for administration to the recipient.

Another significant and important obstacle to the safe transfusion of blood was breached by Braxton Hicks, in 1869, when he administered the first recorded indirect transfusion by adding an anti-

coagulant, phosphate of soda, to the blood of the donor. In 1892, twenty-one years after extensive studies of blood sera and plasma by Bowditch, Von Ziemssen developed his team of trained assistants for the direct type of multiple syringe and needle blood transfusion.

In retrospect, therefore, the first step towards the goal achieved in the present, the simple technique and safety of today's blood transfusion, was the conception of the potential benefits of blood transfusion, as conceived in the mind of some physician whose name was lost in antiquity. The second important step, likewise lost in antiquity, was the actual application of that thought to the benefit of the first recipient. The third step was embodied in the efforts of many investigators to overcome the mechanical difficulties involved and to develop a simplified, workable technique. The fourth and most important step in the long series of brilliant contributions was that of Landsteiner, in 1900, when he developed the first group classification of the blood. This group classification of blood, corroborated by Jansky in 1907, followed the discovery of iso-agglutinins in the blood, by both Landsteiner and Shattock, earlier in the year 1900. Hektoen, in 1907, suggested the adaptability of the Landsteiner blood grouping to the selection of blood donors.

By 1907, Crile offered a direct method of blood transfusion which, although an improvement on the technique of Von Ziemssen, presented the following disadvantages: (1) The necessity of considerable surgical skill. (2) No gauge to estimate accurately the quantity of blood administered. (3) Sacrifice of the donor's artery. (4) Inability to use the same donor on more than one or two occasions. (5) Danger of disease transmission. (6) Danger of severing the fine anastamosis through the slightest movement on the part of either donor or recipient.

By 1910 and 1911, Schultz and Ottenberg were making practical application of Landsteiner's blood grouping technique, in determining compatability of donor and recipient for blood transfusion. The medical literature was shortly thereafter replete with case reports and series case reports pertinent to blood transfusion. One of the earlier survey reports was that of Ottenberg and Kalisher, in 1913. In one hundred and twenty-eight human blood transfusions they had suffered three fatalities. In all cases reported, both the donor and recipient had been carefully tested by the Landsteiner technique for compatibility. One of these fatalities had succumbed within eight hours of transfusion, another within forty-eight hours. In point of fact, numerous instances of hemolytic reactions appeared in the literature that same year.

In the two years following the appearance of these reports, numerous investigators attempted to improve blood transfusion technique, while others resorted to earlier methods long since discarded. Von Ziemssen's technique was reintroduced by Lindemann, in 1915, but it was received once more with skepticism; the disadvantages attendant to a team of trained assistants were only too apparent. Blundell's syringe method was revived, and while it met the pressure requirement, it too was again discarded because of the dangers of blood coagulation and the lack of simplicity in operation. Paraffin-lined tubes and receptacles were introduced by Kimpton and Brown in 1913; this method enjoyed a vogue for some time and was used in a number of clinics as late as 1937. The semi-direct method of Lower and Bernstein was introduced in 1915. This technique was a modification of that expounded by Crile in 1907, and it too was discontinued in short order once it had grown apparent that few of the disadvantages of the Crile technique had been overcome.

Unger and Miller, in 1915, offered their semi-direct, stop-cock, closed system of blood transfusion, a technique which has remained popular with many operators to the present day. But it was destined to be discarded eventually, for one of the reasons that the Crile and other techniques were discarded: in net, the necessity of trained assistants.

In the pre-war years antedating World War I the conviction that indirect techniques would eventually furnish the maximum in simplicity and safety had steadily gained ground in the thinking of various scientific schools. Hustin's technique of utilizing diluted blood mixed with sodium citrate and dextrose had, therefore, been favorably received in 1914, and when Agote and Lewisohn in the following year detailed the precise amounts of sodium citrate required for each 100 cc. of donor's blood, the citrated blood technique promptly became the method of choice, and remained that for the duration of World War I.

It was in those anxious years of the first World War, incidentally, that blood substitutes in the treatment of shock came to the fore with such emphasis that their careful study in the years following was assured. Ready availability, ease in transportation, simplicity in administration, effectiveness—all these features underscored their value in time of war even though each substitute was conceded to be inferior to blood under different, more ideal circumstances.

1. *Intravenous saline, glucose and saline, and glucose and water solutions,* first introduced by Schaefer, in 1878, increased greatly in popularity because of their value in temporarily restoring blood volume. However, this lasted only a short time.

2. *Gum Acacia,* introduced experimentally by Ludwig, in 1863, and clinically by Morowitz, in 1906, was used extensively after 1916, when Bayliss stressed the advantages (of 6 per cent Acacia in saline) in restoring and maintaining the blood volume. Subsequent studies defined the advantages: (1) supposedly lacking in toxicity, (2) possessing viscosity identical to blood, (3) maintenance of osmotic pressure due to colloid; and disadvantages:

(1) temporary effect only—out of the circulation in forty-eight hours, (2) produces a rise in the sedimentation rate, (3) reductions of plasma proteins on repeated injections — possibly through blockage of the reticulo-endothelial cells of the liver, (4) anaphylactic reactions occurring with repeated infusions of this substitute.

3. *Gelatin (3½ per cent to 6 per cent)* in saline, first suggested by Dastre and Floresco, in 1897, and projected clinically by Hoga, in 1915, was found, despite its disadvantages, to be superior to colloid-free solutions. Both its advantages and disadvantages were recognized and listed: advantages: (1) nonantigenic, (2) nontoxic, (3) when sterilized by autoclave and Seitz filter, no preservative required, (4) inexpensive, (5) blood volume increase persisting 24 to 48 hours, (6) easily available; disadvantages: (1) relatively ineffective, (2) deserts the blood stream rapidly, (3) tendency to coagulate (intravascular clotting), (4) gels at low temperature, (5) pseudo-agglutination of RBC—which may be corrected by addition of 1 per cent gelatin, (6) increased sedimentation rate, (7) febrile reactions and fatalities.

4. *Defibrinated human blood* in fresh human serum, as suggested by Maldovan, in 1910, was never popular because of the danger of death from intravascular clotting.

5. *Ascitic fluid*: Feldman in 1928, Hancock in 1936, Hansen-Pruss in 1936, and Davis-White in 1938, carried out exhaustive experiments using ascitic fluid as a blood substitute. It had several disadvantages, namely, the protein content is only one-half that of human plasma, typing is necessary because of the presence of agglutinins, and the necessity of refrigeration and warming prior to use. All these have kept ascitic fluid in the experimental stage and work on this is continuing.

6. *Burger's contribution in 1915* (the use of hemoglobin in saline, Ringer's or Locke's solutions) was carefully investigated by Amberson and associates in 1934, and by O'Shaughnessy, Mansell, and Sloane in 1939. Despite certain advantages, its disadvantages have precluded its extensive use to this day. Advantages: (1) higher colloidal-osmotic pressure than plasma, (2) transports oxygen, (3) stimulates production of RBCs, (4) increases storage of iron in liver, spleen, bone marrow; disadvantages: (1) toxic because of stomata, (2) as hemoglobin in weak antigen it induces a mild anaphylaxis.

7. *Amino acids*, from 1902 until the present, have assumed some importance when administered orally, rectally, or intravenously in the treatment of gastric and duodenal ulcer, other severe gastrointestinal diseases, persistent regurgitation, and advanced cases of inanition through inadequate protein intake.

8. *Amigen* has enjoyed a certain vogue, as an adjunct to plasma, because of the alleged tendency to prevent liver damage. (Amigen must never be used if it is cloudy, and if part of the amigen has been used, the remainder should be discarded.) It should never be restored.

9. *Crystaline hemoglobin* has been studied as a method for restoring the hemoglobin content of the blood and at the present time these studies are being continued. The disadvantages of crystalline hemoglobin have been pyrexia with transient chills, nausea, regurgitation, and abdominal pain. All these have militated against its general acceptance by the profession to the present date.

10. *Plasma.* In World War II dried plasma and plasma occupied the center of the replacement therapy stage. The advantages of plasma were found to be diverse and legend: (1) kept several months without deterioration, (2) ease of preparation, (3) economical, (4) no additional water required, (5) once properly thawed, ready for use without filtration (rapid thawing advised). The only disadvantages to plasma, in point of fact, were difficulties in storage and transportation because of its bulk and weight. These disadvantages were largely overcome by the use of dried plasma. The only determinable disadvantage to the latter has been corrected by the Baxter bottle and by weighing. This shows the variant in the degree of desiccation from one batch of dried plasma to another. Advantages of dried plasma were therefore considered remarkable: (1) increased simplicity and speed of administration by syringe, (2) maximum advantage attained through use in hypertonic form (4 times concentration), (3) ideal for storage and transportation, (4) resoluble in 30-120 seconds, (5) does not support bacterial growth, (6) proteins preserved without change, (7) reduction in bulk and weight through decrease in water carried, (8) the ideal treatment of shock.

Plasma furthermore fitted mass production requirements safely and easily, through mechanized collection, through pooling whole bloods, by ease of plasma separation with De Laval type continuous separator, through Seitz filtration, by ease of bulk desiccation by adtevac process, through the packing of maximum quantity in the minimum space through use of ordinary vaccine vials and sterile mechanical dispenser, and by ease of maintaining bacteriologic control at all steps in preparation and use.

11. *Human blood serum* has had much use in World War II. It, like plasma, was very efficacious in the emergency treatment of shock, burns, head injuries, and nephrosis. It aided in correcting hypoproteinemic states. It also acts as an excellent diuretic in nephrosis. Its disadvantages were maintenance of sterility and prevention of progressive deterioration. It is safe in the form of dry serum which is prepared by evaporation in a sterile cabinet at room temperature and is also safe in the frozen state, which is prepared in a high vacuum.

12. *Modified globin* has been used. It is not of much value because of the vasomotor effect on the patient. It also may cause clotting within the blood vessel. Work on this preparation is continuing.

13. *Erythrocyte suspension* is an isotonic saline solution which is kept at 2 to 5 degrees centigrade. It is a very useful prescription for anemia. However, the hemoglobin increases more rapidly with it than whole blood solutions. The dosage is one to two litres.

14. *Human serum albumin* was presented to the profession by S. J. Cohn. He was able to inject his in four times the concentration of plasma and this gave the advantage of compactness, sterility, and the ability to re-dissolve with any diluent. He divided the plasma proteins into four constituents: (1) those proteins which were concerned with respiration (hemoglobin), (2) those proteins concerned with blood clotting, (3) those which have immune properties, (4) those which control osmotic pressure, the water control, and the electrolyte balance in the body.

Cohn says that each of the above groups are specialized in a way appropriate to their respective physiological functions. Serum albumin has great solubility and stability in solution. It can be purified and prepared in crystalline form and it has the advantage of being compact and sterile when given in strong solutions. The human plasma albumin occurs in 60 per cent of the plasma protein and has 80 per cent of osmotic efficiency of the plasma. Its advantages are that it restores blood values after shock, it is stable and may be dispensed in solution, and 25 per cent solution is isoviscous with whole blood. (The human blood plasma albumin is now on the market. More research is going on.)

15. *Protein digests.* These are not real blood substitutes and may be used to increase the blood proteins in an emergency. Made from caseins, et cetera.

16. *Isinglass* has been used in solution but has the same disadvantages as Acacia.

17. *Pectin* also has been used but is similar to Acacia.

18. *Dextran* was presented in England by Cronwalk-Inglewan in 1945. Its advantages are: same colloidal osmotic pressure as plasma, nonantigenic, atoxic, low viscosity, and easily eliminated by the body. This work is now going on and may become very valuable.

19. *Whole human blood* is the ideal and best blood substitute. It contains all of the necessary constituents, it may be given by direct or indirect route, and it may be used whole, citrated, or stored. Disodium citrate and glucose have been used as preservatives. One hundred cc. of 2 per cent disodium citrate with 20 cc. of 15 per cent glucose may be added to 420 to 430 cc. of blood. Its advantages are: superior preservative power, easily given, is the nearest to normal blood, and comparatively safe. Its disadvantages are: typing, RH factor, and transferring disease (which may be in an incubation stage or in a latent stage).

20. *Polyvinyl alcohol* (PVA RH 623) used as colloids, as blood or plasma substitutes. (Used in 4 per cent solution.) Advantages: (1) is innocuous to recipient, (2) maintains B.P. as well as whole blood transfusions, (3) is lost from blood stream at same rate as plasma proteins regenerate, (4) nonantigenic, (5) low cost, (6) ease of preparation and stability, (7) valuable as a first treatment for hemorrhage and shock. Disadvantages: (1) those of inert substitutes: a. do not promote healing, b. are not foods, c. do not contribute to hemostasis by clotting (large amounts may prevent clotting by diluting the fibrinogen), d. the nonprotein nature lessens the likelihood of antaphylactic shock (it is valueless in anemias and infections).

21. Research is now being done on gamma globulin (11 per cent of plasma protein) to ascertain the uses and values of euglobulin. Pseudoglobulin is used in measles treatment (5 per cent of plasma protein).

Discussion

The drugs which are used today for intravenous medication are: saline and glucose solution, gelatin 3½ to 6 per cent, plasma, human blood serum, human serum albumin, human blood in polyvinyl alcohol, and amigen. These drugs are used in many hospitals to replace the proteins which have been lost. They are especially indicated when the patient has a gastroenteric obstruction due to some disease of the gastrointestinal tract, when patients cannot take food by mouth, and when patients cannot assimilate protein. In cases of trauma, hemorrhage, burns, and for the treatment of hypoproteinemia and nephrosis, albumin which has been extracted from normal human plasma is indicated.

For years plasma has been very valuable in the treatment of all types of shock and in replacement therapy.

The most valuable substance is human blood. It helps in every case and the only contraindication to its use is a condition in which the donor's blood contains a disease not shown in the blood test. However, I believe that it is very worthwhile to use human blood whenever possible after it has been properly tested.

Conclusions

After this epitome of the study of blood substitutes, the author believes that it is the consensus of medical workers on this subject that whole blood is the most valuable substitute. Blood plasma is a close runner-up, and in turn it is followed by blood serum. Human albumin with its special factions is very valuable and its future seems to be a huge unknown. The daily and even hourly use of intravenous saline, glucose, and glucose in saline will always be found in good hospitals.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

Editorials

ROSCOE LLOYD SENSENICH

IT is a rare occasion, indeed, when one "makes" the front page of THE JOURNAL; in fact, we do not recall when this has happened before. But, in this instance, the stage was so set that all connected with our magazine felt that when so signal an honor had come to a Hoosier physician it would be eminently proper to put that man "right out in front."

Indiana Medicine has been the recipient of many honors in its almost one hundred years of organization, and this is the third time that one of our members has been selected as the head of the parent organization, the American Medical Association.

In thus honoring Doctor Sensenich, the A.M.A. not only gives a merited, personal recognition to one who for years past has devoted much of his time in its behalf, but gives due recognition to the fact that the doctor's native state of Indiana has, through the years, done much to foster and to forward every medical movement of note.

Doctor Sensenich, born in 1882, graduated from the Rush Medical College in 1905 and soon thereafter located in South Bend, where he has resided ever since. Of later years he has limited his practice to internal medicine, holding the Board Certificate in that specialty.

We recall what might be termed his debut in Indiana medicine, the first time he attended one of our annual conventions. Soon thereafter he was given a committee assignment, did his work thereon so well that promotion after promotion came his way, and in due time he was named as president-elect, the same year that Dr. Walter Leach, of New Albany, took over as president. Soon thereafter Doctor Leach became ill, followed in a short time by his death, whereupon Doctor Sensenich assumed the duties of president, thus giving him almost two years of service in that position.

Not long after that he was named to the Board of Trustees of the American Medical Association, his tenth year expiring this year. During the past few years he has served as chairman of the Board.

Few men in American medicine are so well known as Doctor Sensenich; he has traveled all over the country in his official capacities and it is said he has been in Washington so often, during the past five or six years, that every one there knows him, including the corner policemen.

When the "Blitz" struck at American Medicine, when a few short-sighted persons, including members of Congress, decided to revamp the entire picture and to break down the accomplishments of a century, Roscoe, as he is known to everybody, put on his armor, got out his old battle-axe, filled that unusually large brief case with a lot of facts and figures, then set out to meet the numerous would-be Goliaths. He met them in state meetings and in Washington. We do not know of a single hearing on any of the so-called health bills that he did not attend. In fact, he went about so much that the old brief case, which had been his trademark for years, gave up the ghost, so Roscoe had to buy a new and larger one.

There appears to have been no "politics" in the elevation of Doctor Sensenich to the highest office in the province of American medicine to bestow—it is but the recognition of true worth, of an indefatigable worker, of a man competent to meet any and all responsibilities that will arise during his term of office.

Such, in brief, is the explanation of our front cover; it is but a feeble means of expressing the pleasure of Hoosier medicine in the honor that has come to Doctor Sensenich—and to us.

HEILMAN CURTIS WADSWORTH

IT is with deep regret that we record the passing of Dr. H. C. Wadsworth, of Washington, one of the "old wheel horses" of the Indiana State Medical Association. It seems we always had known the man and through the many years of acquaintance with him have met him at all the annual meetings, plus sessions of the Council and various other committee gatherings. He had a most notable career of service in the association, beginning with the secretaryship of the Daviess County Medical Society, in 1914. He occupied this post for some four years, again taking over in 1921, to serve until 1929.

Then for two years he served as a member of the Secretaries' Conference, and the following year was named as District Councilor, serving until 1942, resigning at that time because of failing health.

He also served for eight years as a member of the Commitee on Study of High School Athletics, in which he was vitally interested. We recall that when his home high school won their first state championship there was no man in Indiana prouder than he.

Doctor Wadsworth was an enthusiast; whatever he believed in was sure to have his devoted attention. He was a man of strong convictions and "made no bones" about expressing himself on those same convictions. He would preach, exhort, cajole, and command, all in turn, to gain his point.

He was born in 1878 and graduated from Rush Medical College in 1909, later locating in Washington, where he carried on his practice until his retirement, a few years ago.

Only recently we were talking with a former patient of his, recently removed to Hammond. She said, "I do not know what we are going to do without Doctor Wadsworth; he has been our doctor ever since I can remember. And, he was more than just the family doctor—he was our counselor in about everything we did."

Thus do we again mark the passing of a great and good man, one of the finest type of doctors, "The Family Doctor."

A NOTABLE ANNIVERSARY

THE United States Army Air Forces will celebrate its fortieth anniversary on August first, and General Carl Spaatz, its commanding general, plans to make this a momentous occasion. This is as it should be, since no other country has made such progress in this field as have we. The compilation of all the accomplishments of this brief span of years makes a formidable list, indeed.

Among the most notable of these is the pioneering in ground-to-air radio communication; the flying of the first mail route, Washington to New York, in 1918; the free type parachute pack; radio beacon, this in 1925, and blind instrument flying. All these, with innumerable others, have filled these forty years with the most important advances in aviation in the somewhat brief life of that industry.

In the recent war the Army Air Forces made history, history that will live throughout the ages. It takes its place right alongside the Army, the Navy and the Marines. To many, it was the deciding factor in victory.

But with all these achievements it is clear that the work of this organization is but beginning; there are many problems to be solved, many changes to be made in equipment, and many alterations in the plan for permanent personnel. All these are well known to General Spaatz and his able assistants, and we have no doubt that all these problems will be solved in due time. As the General so aptly puts it, "It is my hope that Air Force Day will become a symbol of American progress and that it will serve to keep our people aware of the need for air power if we are to retain our freedom and greatness."

Now this thing called "air power," so it seems to us, is but peace power; it will do more to bring about and to maintain peace than any other single agency. The lessons learned in the greatest war in history have pointed out the way to future greatness, in this field. We have learned, through our errors and mistakes, of the things that must be

overcome—and steps are now being taken to do these very things.

As has been suggested, the personnel of this vast department is being altered, plans are in the making for enabling those of our youth so air-minded to make the Army Air Forces their career. A study of the present plans indicates that not only will these young men receive an aeronautical education, the cost of which would be prohibitive, but, in addition, education in other lines is not to be neglected. Some, whose record in their earlier training is of unusually high standards, will be certified to West Point for further study and training.

In addition, the "pay" is good, what with the various allowances; a leave of absence of thirty days, with pay, each year, adds to the picture. Travel comes in for its share of consideration for our Army Air Forces now are global—they cover the earth.

As the plans now in contemplation are carried out there will be a need for more men, and this means more officers. The American youth, most of whom have at one time or another aspired to become pilots, or at least to be connected in some official capacity with aeronautics, now would seem to have their opportunity.

And to the American people at large, this expansion program, we are sure, will be most appealing; all of us know what the Army Air Forces meant in the darkest days of the late war, all of us know the heartening that came to us when this Force came into its own.

Hail to "Air Force Day," and in succeeding years may it continue to grow in popularity until it becomes a day of universal celebration. For, be it remembered, AIR POWER IS PEACE!

SHORTAGE OF PHYSICIANS

FOR several years past there has been evidenced much concern regarding a shortage in manpower in the medical profession. During the recent war years this amounted to a real problem, much more acute than in previous years. Among the remedies was a stepping-up in our medical schools, they carried on for the full years, rather than on the three-quarter system. This, of course, provided many additional graduates.

However, with the recent report of the A.M.A. Council on Hospitals and Medical Education comes the observation that we still are confronted with a shortage in no small degree. Although the year 1946 saw the graduation of almost 7,000 doctors the physician population in this country had been increased by only 3,601 new doctors. Much of this is due to the large number of deaths among physicians in that year, plus the fact that there are a large number still serving in foreign countries.

The report on licensure for 1946 provides some interesting data, over 16,000 medical licenses had been issued in the 48 states.

Many of these were issued to recent graduates, while a larger number were given to those coming from other states. Many of the latter were ex-service men seeking new locations. California led the list, with more than 2,000 licenses issued, with New York and Illinois going over the 1,000 mark. No state, so it is reported, issued less than 30 licenses. Three states issued fewer licenses than in the preceding year, among these being our own Indiana.

Another feature of the report has to do with failures at the time of the examinations. The report shows that 9.9 per cent of all those taking the 1946 examinations failed. It is worthy of note that the far greater majority of these were graduated either from foreign schools or from the few unapproved schools still operating in this country. Thirteen of our approved schools had no failures, though graduates took their examinations in all sections of the country.

The East North Central and the Atlantic areas seem to have had the greatest number of acquisitions of new doctors.

"THE PURPOSE OF A MEDICAL JOURNAL"

UNDER this title John E. Farrell, Executive Secretary of the Rhode Island Medical Society, addressed the county society secretaries of Connecticut, recently. Mr. Farrell, one of the "live" secretaries, is well qualified to speak on this subject and much that he had to say is worthy of note.

He compares medical journalism with lay journalism—they both have, or should have—the same objectives, that of furnishing to their readers reports of current and prospective events in their respective fields. He further observes that too many of our journals do not come up to the mark of *real* journalism and offers some suggestion for improvement.

He prefers, and in this we agree, that State Journals will do well to leave original scientific clinical discoveries with the national and specialty publications. "The State Journal should seek to present the short, current medical papers, tinged with the personality of the author." Again shall we have to agree with Mr. Farrell.

Again, he speaks of the "seasonableness" of the papers, a most important thing. Certain diseases seem to select certain seasons of the year for their activities and it is at this time that articles,

written from personal experiences, will be best received by readers. He also favors our keeping in touch with many of the "health organizations," even though lay controlled; their annual meetings often provide interesting reading material for physicians.

Mr. Farrell criticizes the editorial department of many of our journals, most of them, in fact; says that while the editorial department is the heart of these journals, "it does not beat loudly in most states." Narrow-minded opinions and controversial matters should be avoided—we are speaking not only to our own membership but to the medical profession of America.

He believes we should be more militant, especially when attacked as we have been for several years past, too many words are used in talking about these things, too few in pointing out why this or that is wrong.

He then strikes a new note when he speaks of the reporting of medical meetings within one's state—too much attention is given to reports of the annual state meeting, too little of what goes on in the county societies. He strongly criticizes the all-too-frequent use of "fillers," these items being sent in by various agencies and too often not edited, but used "as is."

His address is of unusual interest to those concerned with the publication of our state journals and covers the field very nicely. However, we should like to make this comment—we do not believe that a single pattern can be set for all state medical journals to follow; there is too much variation throughout the states. What will be found of the greatest interest in one state will fall absolutely flat in another. Some states, for example—Indiana being a devout believer in the plan—have a regular news notes and personals department. Our readers like this, so they tell us—on the other hand it would fail to interest perhaps some other communities. We like to feel that our publication is, primarily, for Hoosier physicians; we have lived a long time among them and believe we know them.

1947 INSTRUCTIONAL COURSE

The schedule of classes for the 1947 Instructional Course, which will be offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick, will be carried in the August issue of THE JOURNAL, together with an application blank for reservations for the courses.

Editorial Notes

Elsewhere in this number is a special article concerning the actions of the A.M.A. House of Delegates at the Atlantic City centennial meeting. Each year THE JOURNAL assigns to one of our four House members the job of making this special report; later on, from time to time, we will comment on the various actions of the House.

In the morning mail came a little reminder from Ruth Kirk, executive secretary of the State Medical Board, informing us that that Board was now ready to function under the recent registration law and to fill out a small card, get a **certified check** from our banker and send same in, forthwith. We had anticipated a long communication, telling us just what was what and all that sort of thing, so when we received the digest of the law—about the size of a penny post card—we were somewhat disappointed. However, in her usual brisk style, Miss Kirk made it plain that R-Day had arrived and we had better get busy and attend to this little chore, right now. There is a dead line and woe be he who fails to meet it—it will cost just double to correct the error you have made.

Frankly, we long have wished that there were an annual registration; the cost is so little while its advantages are so numerous. It is our prediction that this registration law will uncover "scads" of folk now practicing the healing art, right here in Indiana, who have no license so to do.

We recall some stories that came along about the time the 1897 law became effective. A prominent Hoosier surgeon somehow or other failed to register. In his home city there lived another surgeon, a member of the State Board. These two men had, for some years, had personal difficulties and the Board member took full advantage of the situation; it was some months before the erring surgeon was able to register and meet the requirements of the law. In another instance, during our time as a Board member, a highly respectable practitioner in Indianapolis discovered that he had no Indiana license to practice his profession. After much discussion the Board permitted this man to take the annual examination, this some twenty years after his graduation.

The "big thing" is—send in your card, plus the five dollars, right now.

Dr. William J. Moenkhaus, professor-emeritus of physiology, University of Indiana Medical School, died recently, following an attack of coronary thrombosis. He was seventy-six years of age. A native of Indiana, he was born at Huntingburg and graduated from Indiana University with the degree of A.B. in 1894, receiving from his Alma Mater the degree of A.M. in 1895. He then went to Harvard University as a graduate student, and after a period in Brazil, returned to this country, to receive his Ph.D. degree at the University of Chicago. In 1904, when Indiana University took over the School of Medicine, Doctor Moenkhaus was named as the head of the department of physiology, which post he held until his retirement. Doctor Moenkhaus was generally recognized as a leader in his field, particularly in his knowledge of the sympathetic system; here he was recognized as an ultimate authority. His passing will be regretted by the thousands of Hoosier physicians who have had the privilege of studying under him.

An editorial in the June 7 issue of *J.A.M.A.* brings to mind some interesting recollections of our experiences while a member of the state medical board, some time ago. This article refers to the 1945 Tennessee law which brought about a naturopathic licensing board. Soon after its passage a big "field day" was held down in Nashville, a vast number of cult members assembling for the occasion, they having been invited to come from all over the country. It is estimated that this board passed out some 1,500 licenses to practice this branch of drugless healing in Tennessee. Some time ago a local newspaper sent one of its reporters to consult with one of this gentry, who advised that the reporter was seriously ill, being "eaten up with sinuses," in addition to having stomach ulcers and whatnot—the usual line of guff handed out by this type of ignorant "healer." Of course, the victim was given local treatment, plus three prescriptions for drugs, all of which resulted in the "naturo" being fined in the sum of $500 and a sentence of almost a year in the county workhouse. 'Twas ever thus! Give these chaps an inch of rope and they will at once proceed to make it a mile. Reminds us of the Connecticut and Arkansas scandals of some years ago, when Eclectic Boards passed out state licenses like handbills—for a consideration. Particularly did they deal with at least three fake "diploma mills" in Kansas City and St. Louis, all of which subsequently were exposed by the *St. Louis Star*. These Arkansas and Connecticut licensees soon spread out all over the country—we had three of them in Lake County at one time—and it was a matter of several years before they were put out of business.

Notwithstanding the wet season, the Indiana Canners Association predicts a normal tomato crop for 1947, which means that we will be back on a pre-war basis. As we often have remarked, Indiana is the banner tomato state, "putting up" more canned product than any other state. And, somehow or other, the quality of Indiana tomatoes is tops, so that the *one hundred thousand acres* to be set out this year not only will feed thousands of people, but will bring large financial returns to all concerned. In our little plot we have the usual number of plants, all doing exceptionally well; we still stick to Rutgers and Marglobe, with two or three Jubilee plants, and not forgetting a couple of small Yellow Pear, these latter for the grandchildren.

Again during these summer months outbreaks of poliomyelitis are making their appearance in many sections of the country. Last year 25,191 cases occurred in the nation, 433 of them within this state. No one can forecast how many cases will occur this year or how badly the communities in this area will be affected. Medical science, unfortunately, cannot as yet prevent an epidemic or even one case.

Physicians in this area, as well as elsewhere, are aware of the multitude of problems poliomyelitis presents. Treatment of the disease is apt to be prolonged and extremely costly, requiring the services of many specialists. Too often the patient's family looks to the physician for advice and guidance far beyond the immediate problem of medical care.

In times such as these it is helpful to physicians to know that there are others prepared to share these troublesome burdens. In addition to making possible epidemic aid, education, and scientific research, the National Foundation for Infantile Paralysis is pledged to assist financially those patients who require such help. Through their generous contributions to the March of Dimes, the American people have made this possible. Hospital bills, salaries for physical therapists and nurses, purchase of special equipment, and the many other charges which may comprise the essentials of good medical care may be paid for by the chapters of the National Foundation when necessary. There is a chapter of the National Foundation in each of the 92 counties in Indiana.

Physicians serve on the local chapter's Medical Advisory Committee, guiding the chapter in developing medical care programs and solving allied problems. THE JOURNAL urges you to cooperate with National Foundation chapters in furthering their programs of medical care. Notify the local chapter when a poliomyelitis patient comes under your supervision. Make certain that the family of your patient knows of the chapter's existence and willingness to assist. By so doing you will be performing an essential service to your patient and relieving yourself of many unnecessary burdens.

Well, it's not *too* long until October comes along, bringing with it our annual convention, this year to be held at French Lick. We are advised that the pre-convention registration is unusually heavy, hence it would be well for each member planning to attend to make the proper reservations, right now. As we often have remarked, October is an ideal time to visit that part of Indiana, and the many changes in the hotel accommodations furnish an additional incentive to want to go down and see just what has been done. *Make that reservation right now!*

Some 26,000 doctors who were in Army and Navy service during the recent war replied to questionnaires sent out by the Committee on National Emergency Service, of the A.M.A. A compilation of these replies shows many interesting things, not the least of which is the fact that men in service were not nearly as busy as those who remained at home to take care of civilian practice. The full report, as prepared by the director of the Bureau of Economic Research, and published in *J.A.M.A.* for June 7, makes most interesting reading. The report indicates that most service officers had plenty of time on their hands. It is believed that when the findings are complete American Medicine will be able to tell the Army and Navy just how many medical officers they will require to carry on properly, both in time of war and in time of peace.

The matter of home heating is getting to be quite a problem; no sooner do we arrive at a satisfactory answer when along comes something or other that upsets our program. Through a period of more than seven decades we have made numerous observations in this regard. Back in our Wild Cat days we knew nothing but wood as a heating element, this being used in the kitchen stove, the fireplace and the "big stove" in the living room—no heat on the upper floor, save what came through floor registers. Later on, we acquired a "base burner," using anthracite coal, which was a big help. Moving to Frankfort in the early "nineties" we came upon natural gas—later that petered out and we went back to coal. Moving to Lake County, we again returned to anthracite coal, years later installing an oil plant. In due time, along came OPA with "oil tickets," which meant for most of us inadequate heat. Then we installed a gas-heating plant—very satisfactory. Fortunate indeed we were, since gas heat plants no longer are available—there just is not enough gas to go 'round! So, lots of folk will have to go back to their hand-fired and stoker-fired furnaces, hoping that the bushy-browed *Coal Boss* will let them have enough to keep warm this next winter. Indiana officials have made every effort to be permitted to tap the "Big Inch" gas mains that cross our state, coming from the Texas and Oklahoma oil fields, but so far with no success, seems they want this gas "down East."

Report of Epilepsy or Similar Disorders Characterized by Lapses of Consciousness

Chapter 9 of the Acts of 1947 Indiana General Assembly requires that all physicians report within ten days to the State Board of Health, in writing, the name, age, and address of every person diagnosed by him as a case of epilepsy or similar disorders characterized by lapses of consciousness. On the first day of each month the Board of Health must transmit the names of individuals so reported to the State Bureau of Motor Vehicles.

For the convenience of the physicians, the Board of Health has prepared a form, reproduced below, on which such reports may be made. These forms may be secured by addressing the Indiana State Board of Health, 1098 West Michigan Street, Indianapolis, Indiana.

CONFIDENTIAL Report of Epilepsy or Similar Disorders Characterized by Lapses of Consciousness
To
Indiana State Board of Health
1098 West Michigan Street
Indianapolis, Indiana

This is to certify that_____, _____, _____, _____
Name Age Sex Color

residing at _____, _____, _____,
Street City County

has been diagnosed by me as a case of_____
Epilepsy or similar disorder

_____, M. D.
Physician's Signature

(If you desire, report may be made by letter.)

President's Page

PLOWING AND SEEDING

As these words are written, the spring planting season has come to a close. Your executive secretary and yours truly, ably and effectively abetted by your president-elect, have visited every district society in this great state. To each and every member has been carried messages of information re the many and varied activities of your association. In addition, live contact has been maintained with the representatives in our General Assembly, the state tuberculosis society, the state cancer control society, the state otorhinolaryngologists, the state ob-gyn society, the secretaries of the eighty-three component county societies, the state industrial health program, the Indiana State Board of Health, the Board of Medical Registration and Licensure, and the Indiana State Dental Association. The planted seed is a hybrid Hoosier-Dutch. The soil is fertile. In true Hoosier home-spun, may the crop be better than "knee-high by the Fourth of July."

IMPRESSIONS

The numerical membership of your association now stands at 3,618, an all-time high. The attendance at the district meetings has been exceptionally good. The interest maintained during the very excellent scientific presentations has been superb. Every member present seemed eager to learn. The entertainment and spirit of social enjoyment leave little to be desired. Time after time the question was asked: "You fellows at the top-flight level seem to be doing many things for and giving so much time to our association, what can we do?"

THE ANSWER

Much! Attend your society meetings 100 per cent! Participate in its programs. Rise to discuss its problems. Practice good medicine in your community. Maintain good public relations—see that everybody in your county knows that everyone is receiving good medical care. Get acquainted with and learn to know the congressman from your district and your representative in the state legislature. Properly instruct your county-society-elected delegate to your House of Delegates in October, and make sure that he will be present to carry out the wishes of your society. That is the democratic process of free men, free physicians. If he happens to be appointed to a reference committee, make sure that he is impressed with his responsibility, so the manifold business of your association may be conducted with efficiency and dispatch.

RECOMMENDATIONS

Never *again* should a *single representative* who is unfriendly to us as physicians sit in the state General Assembly. The duty of preventing this resides with each county society. You know how.

We should have at least one or more physicians elected to each branch of the General Assembly every biannum. See to it! It will help tremendously. The pay is fair to good for the time involved. The opportunity is without parallel. *We need them there!*

There still reside in Indiana several hundred physicians eligible to membership in our state association! Why not bring them into your county society? It would help.

FLOWERS

This month's boutonnieres are awarded:

For efficient services in HQ while Chevying and Dodging over the state in attendance to district meetings—Ray E. Smith.

For able assistance and active cooperation in affairs of state—Doctor Nafe.

For the phenomenal growth of the Mutual Medical Insurance, Inc.—Doctor Kennedy.

For the continued, eminently sound financial structure of your association—Doctor Weyerbacher.

For a six-month Journal equaled by few and surpassed by none—Doctors Shanklin and Forster.

And thanks so much to every one of you who has helped, even in the very least, to make this first half-year a success.

Sincerely,

Floyd L. Romberger

A.M.A. CENTENNIAL MEETING

Atlantic City, June 9 to 13, 1947

H. G. Hamer, M.D.

INDIANAPOLIS

MORE than 28,000 physicians, their wives and guests, foreign representatives, and exhibitors gathered together in Atlantic City to celebrate the founding of the American Medical Association 100 years ago. It marked the twelfth annual meeting to be held in Atlantic City and the attendance of about 15,000 physicians alone exceeded that of any previous meeting of the A.M.A. and was probably the largest medical assemblage ever convened.

Founded on May 5, 1847, when 250 delegates, representing more than 40 medical societies and 28 colleges, met in the hall of the Academy of Natural Sciences, in Philadelphia, the association has grown to a membership of 132,224, the largest ever recorded.

The significance of this centennial meeting was marked by the issuance of a special stamp by the United States Post Office Department, commemorating the occasion.

The week preceding the official opening of the A.M.A. meeting was filled with annual and special gatherings of no less than 28 specialty groups, and many other pre-convention activities took place.

To attempt to report in detail this vast assemblage and its activities is manifestly impossible, so only the high spots can be given.

On the Saturday preceding the official opening of the A.M.A. meeting the Board of Trustees tendered a dinner to honor the affiliated professions, industries, and leaders in American life. Speaking at this dinner meeting were General Omar Bradley, director of the Veterans Administration; Basil O'Connor, chairman of the American Red Cross and president of the National Foundation for Infantile Paralysis, Inc.; and H. W. Prentis, Jr., president of the Armstrong Cork Company and past president of the National Association of Manufacturers.

On Sunday a special religious service was presented in Convention Hall, while throughout the nation ministers of all faiths called attention from their pulpits to the Centennial Anniversary and the progress of medicine during the last 100 years. At the Atlantic City services addresses were given by Dr. Ralph Cooper Hutchison, president of Lafayette College; Monsignor Fulton J. Sheen, of Catholic University, and Rabbi Joshua Liebman, of Boston. A message from each was also broadcast over the National Broadcasting Company network.

In the afternoon a meeting of the Conference of Presidents and other officers of state medical associations was addressed by L. Howard Schriver, president of the Associated Medical Care Plans, Inc., Major General Paul R. Hawley, chief medical director, Veterans Administration, and Senator Robert A. Taft.

In addition, the first "Grass Roots Conference" of County Medical Society Officers was held, with Dr. A. M. Mitchell, of Terre Haute, as chairman. The purpose of the conference was to bring attention to the problems of various localities and to promote exchange of information on voluntary health insurance plans, hospitalization plans, and improvement in medical facilities, rural health activities, and functions of the various bureaus and councils of the A.M.A. Since no recommendations or resolutions arose out of the meeting, discussions were conducted on the panel system, with questions being answered by a picked "Board of Experts." Such topics as the relationship of the doctors to medical societies, hospitals, specialty boards, postgraduate education, the patient and the public, and legislation were discussed. Medical service problems were considered, including prepayment plans, rural health, labor union programs, Hill-Burton Act, and health centers and fund-raising groups.

Four major activities occupied the physicians during their week's stay in Atlantic City: the scientific exhibit; the technical exhibit; scientific meetings, where over 350 papers were presented; and the sessions of the House of Delegates.

The scientific exhibit, which always offers the greatest interest to the greatest number, was all embracing in its variety of subjects, and superb in the quality of presentation. More than 250 displays, prepared by leading medical investigators and manned by more than 500 research experts, were available for study and explanation. Every method that modern ingenuity has devised for display was utilized in this "World's Fair" of medicine. Photographs, motion pictures (of which there were more than 60), drawings, paintings, plastic models, lantern slides, photomicrographs, charts, and x-ray films were in profusion. Specimens of human tissues and organs, mechanical apparatus, microscopes, and practically every type of diagnostic instrument were available for intensive study of the topic depicted. In spite of the use of the world's largest convention hall, more than 40 per cent of exhibitor applicants had to be turned down because of limited space.

Subjects covered in the major exhibits included the heart, cancer, new drugs, hormones, mental disorders, infantile paralysis, and the newer methods of anesthesia. Four special exhibits on heart disease, physical medicine, fractures, and pathology created much interest because of the large number of demonstrators and instructors presenting the exhibits and topics in relays. Question and answer conferences were conducted on heart disease and

diabetes in conjunction with exhibits on these subjects.

While a great deal of historical material was incorporated in the scientific exhibits, the main emphasis was placed on the principal developments in medicine.

Aids to diagnosis and care of polio patients were presented by a five-panel exhibit, depicting the critical signs of the disease, techniques of muscle examination, and a graphic review of world occurrence. Miniature sculptures and color films reproduced the characteristic signs and muscles involved. Muscle-testing procedures were stressed and physical therapy measures demonstrated. The University of Minnesota had an elaborate display on new methods of treating bulbar poliomyelitis and graphically presented the use of the oximeter, an electronic device which records the amount of oxygen circulating in the blood stream, when clipped on the patient's ear.

Dietary factors in preventing tooth decay; the "uncertain" role of streptomycin in the treatment of tuberculosis; psychosomatic medicine every physician should know; the pessimistic outlook for gastric cancer; high lights on the medical history of the United States Navy; the use of nitrogen mustard in the treatment of Hodgkin's disease and lymphatic disorders; psychic disorders as a factor in the production of certain skin disorders; a longevity and mortality report on American physicians; medical education in relation to industrial health; the electron microscope as an aid in the fight against virus diseases; the importance of exercise after surgery; comparative values in methods of treating syphilis; drug sensitization; the value of transfusions before and after surgery; newer concepts in treating hypertension; the use of anticoagulants in the treatment of heart disease; the injection of amino acids prior to surgery; the immediate removal of kidney stones; refrigeration anesthesia; psychotherapy in everyday practice; the use of liquid oxygen in treating skin diseases; x-ray irradiation in the prevention and treatment of wound infections; synthetic resin ("Amberlite IR IV") to counteract acidity in peptic ulcers; and the formation of a bone bank were all high light subjects for discussion at the scientific assembly meetings. Each section devoted at least one paper to depicting the progress of the specialty during the past 100 years.

The technical exhibits of approximately 400 manufacturing firms, manned by 2,000 persons, demonstrated the latest and best of their products. Some of the exhibits were large and costly and represented a vast amount of work and investigation. Others, of a more modest character, featured products or services or information that have a live interest for the medical profession today.

From the pharmaceutical industry alone more than 50 manufacturers exhibited important products. One firm displayed a replica of an old-fashioned pharmacy, in keeping with the centennial pattern of the meeting. Leading manufacturers of apparatus, instruments, and equipment had extensive showings of new and standard items. Special dietary products and infant feeding materials were presented. Book publishers made it possible for physicians to see and compare books of their particular interest. Hundreds of experts were on hand to discuss and demonstrate their exhibits. Truly, the technical exhibit was a world of interest.

Outstanding exhibits were presented by the Army, Navy, Veterans Administration, and the United States Public Health Service. The Navy showed two of the goats which withstood the atomic bombing at Bikini and their medical records. The Army presented the clinical and pathologic aspects of atomic warfare.

A joint session on "What's New in Medicine" was very well received, as were numerous symposiums on cancer research, virus diseases, therapeutic abortion, liver disease, and ulcerative colitis.

Distinguished foreign guests from all over the world were present in great numbers and were received with respect and appreciation. In addition to greetings, congratulations, and good wishes, many of them brought appropriate gifts and tokens, and the surprising thing was their excellent command and use of English.

The Woman's Auxiliary, numbering some 35,000 in membership, and whose national office is at A.M.A. headquarters in Chicago, met to celebrate their 25th anniversary, and meetings were held concurrently with the A.M.A. In addition to taking an active part in the general meetings and entertaining features of the centennial, a full schedule of activity was dispatched in the organization sessions. One of many features was a luncheon meeting honoring the president, Mrs. Jesse Hamer, of Arizona, and president-elect Mrs. Eustace A. Allen, of Atlanta, Georgia, at which guests of honor were the officers and members of the Board of Trustees of the A.M.A. and their wives. An annual dinner was held on Thursday evening, which climaxed a year of activity devoted to health education work, the study of juvenile delinquency and its control, student nurse recruitment, promotion of the A.M.A.'s 10-point health program, child health and rural health problems, and the study of prepayment medical care plans. At the final session of the House of Delegates, Mrs. Luther Kice, of New York, was elected president-elect.

Wives of Indiana doctors took part in deliberations of the Woman's Auxiliary to the American Medical Association. Mrs. Samuel J. Petronella of East Chicago, immediate past president of the Indiana Auxiliary, read the report of activities during her term of office. The report drew loud applause when it revealed that 308 new members were added in 1946-47, two new units were established, and five counties are in the process of organizing auxiliaries. Mrs. Petronella was honored by appointment to the Elections Committee.

The delegates from Indiana attending the Auxiliary meeting were: Mrs. Charles Voyles of Indian-

apolis, Mrs. N. K. Forster, of Hammond, Mrs. Truman E. Caylor of Bluffton, Mrs. Earl Antes of Evansville, Mrs. C. L. Wise of Camden, Mrs. A. C. Worley of Fort Wayne, Mrs. W. R. Morrison of Kokomo, Mrs. H. R. Stimson of Gary, Mrs. G. M. Young of Gary, Mrs. J. D. McDonald of Evansville, and Mrs. Petronella.

A special feature of the A.M.A. Centennial Meeting was the distribution of $34,000 in United States Savings Bonds, divided into 42 awards by the American Physician's Art Association and Literary Guild, for the best works of art memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty."

One hundred cups were to be awarded in the art exhibit. The bond contest, sponsored in co-operation with Mead Johnson & Company, Evansville, for pictures and sculpture done by physicians depicting the theme, really developed some marvelous work. The non-medical writings—humorous and serious—in various classes of prose and poetry, contested for beautiful plaques. Art subjects were sent in from the entire United States, Canada, Hawaii, the Philippines, and Central and South America. More than 2,000 pieces were submitted for judgment.

While most of the entertainment features were devoted to individual and special groups, the most important social event of the week was the reception and ball for the incoming president, Doctor Bortz. Held in the huge convention hall ballroom, with the officers of the A.M.A. in the receiving lines, the affair was truly a magnificent occasion.

In addition to many alumni and fraternity group reunions, the annual golf tournament was held, and 50 trophies and prizes were distributed to the winners.

Several radio programs were broadcast throughout the convention, chief of which were "Doctors —Then and Now," the religious services, the opening of the scientific and technical exhibits, "Stephen Graham, Family Doctor," and various addresses by the officers of the association.

Indiana has just cause to be proud and happy in the choice of the House of Delegates of Dr. Roscoe Sensenich as president-elect of the A.M.A. Such high honor can come only in recognition of hard work and deserving ability, and Doctor Sensenich has ably demonstrated these traits. In congratulating the man we assume a portion of the reflected glory in claiming him as our own. May his tenure of office be high lighted by progress and marked by accomplishment. No greater honor could come to him, no happier recognition to Indiana.

Doctor Sensenich is the third Indiana physician to be so honored. The other two were Dr. Theophilus Parvin, of Indianapolis, in 1879, and Dr. James F. Hibbard, of Richmond, in 1894. Doctor Sensenich was elected over Dr. James R. Bloss, of West Virginia, by a vote of 123 to 35.

Seven sessions of the House of Delegates were held in four days, with the four Indiana delegates present at every session. They are Dr. Homer G. Hamer, of Indianapolis; Dr. F. S. Crockett, of Lafayette; Dr. Don F. Cameron, of Fort Wayne; and Dr. A. S. Giordano, of South Bend. Two received important conference committee assignments. Doctor Hamer was named to the Committee on General Practice, and Doctor Giordano was appointed to the Committee on Amendments to the Constitution and Bylaws.

One of the most interesting reports of committees given at the opening session was that of the Committee on Rural Medical Service, of which Doctor Crockett is chairman. Doctor Crockett revealed that his committee had unified action for solution of the problem by bringing all interested groups together in conferences.

Space does not permit a detailed report on all actions of the House, many of which were routine. Principal actions were:

1. Directed Board of Trustees to set up a new public relations program after accepting resignation of Raymond Rich and Associates, of New York, as public relations counsel.

2. Established a new section on Diseases of the Chest.

3. Authorized appointment of a Committee on the Nursing Problem to make a study of what may be done to improve the supply of nurses for bed care of patients. It was suggested that nurses' training now places too much emphasis on technical training.

4. Ordered the A.M.A. to make a survey of medical services and hospital facilities throughout the United States through the offices of state medical associations.

5. Expressed opposition to the Taft-Fullbright bill (*S. 140*) because it grouped health with education and security in a new federal department. Expressed approval of the Taft bill (*S. 545*) which would create a single agency on health.

6. Complimented Dr. A. M. Mitchell, of Terre Haute, chairman of the first "Grass Roots" conference for county medical society officers, on the excellency of the program held June 8, and recommended that similar conferences be held in the future.

7. Voted to hold the December House of Delegates meetings in various parts of the country instead of Chicago, and to arrange scientific programs at that time for the benefit of physicians in that area.

8. Selected Chicago as the place for the 1948 meeting, Atlantic City for 1949, and San Francisco for the 1950 convention city.

9. Established a standing A.M.A. Committee on National Emergency Medical Service, after urging that the federal government create a National Emergency Medical Service Administration to mobilize civilian doctors and administer military medicine in event of another war, so mistakes of World War II in handling medical personnel might be avoided.

10. Adopted a resolution asking the Council on

Medical Education and Hospitals to study the requirements of specialty boards and the effect of their regulations on hospital staffs.

The House re-elected Dr. George F. Lull as secretary and general manager; Dr. J. J. Moore, of Chicago, as treasurer; Dr. R. W. Fouts, of Omaha, Nebraska, as speaker of the House; and Dr. F. F. Borzell, of Philadelphia, as vice-speaker of the House.

Dr. E. J. McCormick, of Toledo, was elected to the Board of Trustees, to succeed Doctor Sensenich, and Dr. Dwight H. Murray, of Napa, California, was re-elected a trustee to succeed himself. Dr. Thomas A. McGoldrick, of Brooklyn, was elected vice-president.

So ended the greatest medical show on earth. Such brief reporting has in no way indicated the magnitude of this event. It will live in history for another hundred years as a symbol of progress, a monument to planning and effective effort, and a source of unending, bewildering satisfaction to all who were privileged to attend.

INDIANA PHYSICIANS WHO REGISTERED AT A.M.A. MEETING IN ATLANTIC CITY, JUNE 9-13, 1947

Allen, H. E., Richmond
Allen, J. L., Greenfield
Antes, E. H., Evansville
Appel, R. H., Indianapolis
Armington, R. L., Anderson
Astrom, Algot, Logansport
Bailey, L. S., Zionsville
Baker, Milan D., Culver
Ball, T. Z., Crawfordsville
Baxter, Neal E., Bloomington
Becker, P. H., Crown Point
Beeler, R. C., Indianapolis
Berghoff, R. J., Fort Wayne
Bibler, L. D., Indianapolis
Bickel, D. A., South Bend
Bishop, C. A., South Bend
Blackburn, E., South Bend
Blum, Leon, Terre Haute
Bond, George S., Indianapolis
Booher, Olga Bonke, Indianapolis
Booher, Norman R., Indianapolis
Borders, T. R., Fort Wayne
Bowers, J. A., Kokomo
Bowers, Jesse, Fort Wayne
Browning, J. S., Indianapolis
Bruetsch, W. L., Indianapolis
Bulson, E. L., Fort Wayne
Burney, L. E., Indianapolis
Cameron, Don F., Fort Wayne
Cartwright, E. L., Fort Wayne
Casey, S. M., Huntington
Cassady, J. V., South Bend
Caylor, T. E., Bluffton
Clancy, J. F., Hammond
Clarke, Eldon R., Kokomo
Clauser, E. H., Muncie
Cole, Ira, Lafayette
Combs, Charles N., Terre Haute
Combs, P. B., Evansville
Cortese, T. A., Indianapolis
Crandall, L. A., Elkhart
Crimm, Paul D., Evansville
Crockett, F. S., Lafayette
Culbertson, C. G., Indianapolis
Cullen, Paul K., Indianapolis
Cunningham, G. A., Marion
Custer, E. W., South Bend
Davis, J. B., Marion
Davis, M. S., Marion
Dalton, John E., Indianapolis
Dieckman, H. S., Evansville
Donato, A. M., Indianapolis
Dugan, T. J., Indianapolis
Duggan, J. A., South Bend
Dycus, W. E., Evansville
Ebert, J. Wayne, Indianapolis
Echternacht, A. P., Crawfordsville
Edlavitch, B. M., Fort Wayne
Eisaman, J. L., Bluffton
Ellis, Seth W., Anderson
Eshleman, L. H., Marion
Faltin, Ladislaus, South Bend
Ferrara, D. W., Peru
Ferry, Paul W., Kokomo
Fipp, A. L., Rome City
Fisher, Pierre J., Marion
Fisher, Seymour, Fort Harrison
Folz, Charles J., Evansville
Foreman, W. A., Brookville
Forster, N. K., Hammond
Frankowski, C. E., Whiting
Freeman, F. M., Goshen
Frith, L. G., South Bend
Ganz, Max, Marion
Garling, L. C., Muncie
Gaul, L. E., Evansville
Giordano, A. S., South Bend
Gladstone, Mae H., Fort Wayne
Goodman, Eli, Charlestown
Green, G. F., South Bend
Grillo, Donald, South Bend
Groman, H. C., Hammond
Habich, Carl, Indianapolis
Hall, O. A., Muncie
Hamer, H. G., Indianapolis
Hamilton, E. E., Dayton
Hattendorf, A. Paul, Fort Wayne
Hauss, A. P., New Albany
Henley, Glenn, Fairmount
Herrmann, Gordon, Indianapolis
Herzer, C. C., Evansville
Hines, Don Carlos, Indianapolis
Hippensteel, R. R., Indianapolis
Holland, Philip T., Bloomington
Horton, G. R., Fort Wayne
Hughes, W. F., Jr., Indianapolis
Hurley, A. G., Muncie
Hyatt, G. T., Evansville
Irey, P. R., Plymouth
Johnson, Thomas W., Indianapolis
Johnston, Robert L., Bluffton
Jones, E. S., Hammond
Kammen, Leo, Indianapolis
Kahan, H. L., Gary
Katterjohn, J. C., Indianapolis
Kenney, F. D., Hammond
King, J. W., Anderson
Kirtley, W. R., Indianapolis
Klepinger, H. E., Lafayette
Kohlstaedt, K. G., Indianapolis
Kraft, Bennett, Indianapolis
Kunkler, Joseph, Terre Haute
LaBier, Clarence R., Terre Haute
Lamey, P. J., Anderson
Larkin, B. J., Indianapolis
Lavengood, Russell, Marion
Lee, Glen Ward, Richmond
Lingeman, B. N., Crawfordsville
Linton, E. C., Medaryville
Littell, J. J., Indianapolis

Luckett, C. L., Terre Haute
Lynch, Otis R., Marengo
MacGregor, D. E., Indianapolis
McCaskey, C. H., Indianapolis
McDonald, J. D., Evansville
McIntyre, J. M., Indianapolis
Martin, Hugh E., Indianapolis
Masters, Robert J., Indianapolis
Mitchell, A. M., Terre Haute
Moats, G. E., Fort Wayne
Morrison, W. R., Kokomo
Moser, R. H., Indianapolis
Mothersill, M. H., Indianapolis
Nafe, Cleon A., Indianapolis
Nesbit, L. L., Anderson
Neukamp, F. H., Connersville
Neuwelt, Frank, Gary
Norris, Mary Alice, Indianapolis
O'Rourke, Carroll, Fort Wayne
Otten, C. F., Indianapolis
Owsley, Charlotte M., Hartford City
Padgett, E. E., Indianapolis
Pearson, Lyman R., Indianapolis
Peck, F. B., Indianapolis
Perrin, K. F., Fort Wayne
Petranoff, T. V., Indianapolis
Petronella, S. J., East Chicago
Ralston, J. D., Indianapolis
Reed, Donald, Culver
Rice, Thurman B., Indianapolis
Ricketts, J. W., Indianapolis
Rissing, W. J., Fort Wayne
Roach, C. E., Indianapolis
Robbins, L. C., Indianapolis
Rodriguez, Juan, Fort Wayne
Romberger, F. T., Lafayette
Rosenak, B. D., Indianapolis
Rosenheimer, G. M., South Bend
Row, P. Q., Hammond
Rubin, Milton R., Gary
Schlesinger, Daniel, Hammond
Schulze, William, Vincennes
Scott, Irvin H., Sullivan
Scudder, J. A., Edwardsport
Sensenich, R. L., South Bend
Shattuck, J. C., Brazil
Shields, J. E., Brownstown
Shields, T. S., Brownstown
Short, J. T., Fort Wayne
Siekierski, J. M., Griffith
Skillern, P. G., South Bend
Smith, H. S., Bloomington
Snively, W. D., Jr. Evansville
Spangler, Jesse S., Kokomo
Stayton, C. A., Indianapolis
Steffen, A. J., Wabash
Steffen, J. T., Wabash
Stimson, H. R., Gary
Stinson, D. K., Rochester
Stygall, J. H., Indianapolis
Sedam, H. L., Indianapolis
Tavenner, F. W., Gas City
Tennant, D. L., Fort Wayne
Tischer, E. P., Indianapolis
Tranter, W. F., Sharpsville
Underwood, G. B., Evansville
Urschel, D. L., Mentone
Van Buskirk, E. M., Fort Wayne
Van Winkle, A. J., Valparaiso
Voyles, C. F., Indianapolis
Wagoner, G. W., Delphi
Weigand, C. G., Indianapolis
Weiss, H. G., Evansville
Welborn, M. B., Evansville
Weyerbacher, A. F., Indianapolis
Whallon, A. J., Richmond
Whitlock, F. C., Indianapolis
Whitlock, M. E., Mishawaka
Williams, F. M., Pendleton
Wilson, L. A., Michigan City
Wise, C. L., Camden
Worley, A. C., Fort Wayne
Young, G. M., Gary
Young, R. G., Marion
Zimmerman, Harold, Evansville
Zweig, E. S., Fort Wayne

Curious Ways in which Certain Diseases are Stopped

In Rackeman's recent review of the literature on Allergy (*Arch. Int. Med.* 77:718, 1946) he remarked that an attack of jaundice will relieve asthma and keep it from returning for some time. This fits with the studies of Hench and others who have noted that jaundice in some miraculous way relieves severe and painful arthritis, and it fits with the observation that jaundice is a good cure for migraine. The fact that in a case of crippling arthritis the complete relief of great pain and disability came several days before the jaundice appeared, showed that the essential feature was not the cholemia but the primary injury to the liver. Similarly, Morlock and the writer found that the coming of cirrhosis of the liver, without jaundice, can for some time keep a migrainous person from having sick headaches.

As Rackeman suggested, all of this may fit in with Manwaring's (1921) old observation that a dog sensitized to some allergin cannot react anaphylactically to that substance after its liver has been shunted out by means of an Eck fistula. One wonders also if the remarkable relief that many migrainous women experience during pregnancy, or for some time after an attack of typhoid fever or after an operation, might be due to some temporary impairment of liver function. Curious is the fact that many women who experience perfect relief from migraine in one pregnancy will not get relief in another.

Hench and others have tried in various ways to produce a jaundice which will cure arthritis without hurting the patient, but so far without entire success. It is to be hoped that some day a drug may be found which will depress some function of the liver and in so doing will work the desired miracle of healing in cases of arthritis, asthma and migraine.

Another curious phenomenon well known to gastroenterologists is the prompt disappearance of all ulcer distress following a big hemorrhage from the lesion. That such bleeding has some desensitizing effect on the whole body is suggested by the fact that when the patient suffers also from migraine, hematemesis may bring him a good vacation from that disease too. Still another puzzling observation is that a permanent cure of severe migraine sometimes follows a small stroke.

The editors of Gastroenterology would be pleased if when physicians observe curious phenomena of this type they would write a letter describing them. Out of a collection of such observations might well come hints of great value in the treatment of certain diseases.—W. C. A. in *Gastroenterology*, March 1947.

Official List Of Hotel Accommodations, Rates, And Information

1947 Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick

OCTOBER 28, 29, AND 30

FRENCH LICK SPRINGS HOTEL

Convention Headquarters—600 rooms.

Rooms with bath for single occupancy—$13.00 daily.

Double rooms with bath, twin beds, in de luxe section ("A" section)—$12.00 per day, per person, when occupied by two.

Double rooms with bath, twin beds, main section, and all other outside locations, $11.00 per day, per person, when occupied by two.

Double rooms with bath, back of house, facing dining room, kitchen, and roofs, $10.00 per day, per person, when occupied by two.

Rooms with lavatory and toilet only, for single occupancy, $10.00 per day.

Double rooms, lavatory and toilet only, $9.00 per day, per person, when occupied by two.

Rooms with running water only, $8.00 per day, per person, whether occupied by one or two.

Room rates include all meals, including the annual dinner on Thursday night, October 30. The new owners of the hotel have discontinued breaking down the American plan day into quarters as has been the custom for many years, and have substituted the following system of charging for part days:

Breakfast	$1.50
Lunch	$1.50
Dinner	$2.50

For example, after a guest has completed a full American day of occupancy of his room, but remains for an extra meal or two, when he checks out he will pay for only the full day rate plus the charge for the extra meals, at the prices quoted above.

West Baden Springs Hotel, formerly The Homestead, West Baden—92 rooms.

Double rooms with bath—$5.00 double; $3.00 single.

Double rooms with toilet (no bath)—$4.00 double; $2.50 single.

Double rooms with running water (no toilet or bath)—$3.50 double; $2.00 single.

(Food is not included in above prices).

New Harrison Hotel, West Baden—29 rooms.

Rooms without bath—$2.00 per person.

Doyle's Tourist Home, West Baden—14 rooms.

Rooms with bath on halls—$2.50 double; $1.50 single.

Pierce's Tourist Home, West Baden—6 rooms.

Rooms with bath on halls—$2.50 per person.

Claxton House, French Lick—20 rooms.

Rooms with bath on halls—$1.50 to $2.00 per person.

Grand Hotel, French Lick—30 rooms.

Rooms with bath on halls—$2.00 per person.

(Food is not included in any of the above prices).

A list of available rooms in private homes located in the French Lick-West Baden district is being compiled by the Convention Arrangement Committee. Address inquiries to Dr. C. E. Boyd, co-chairman, in care of French Lick Springs Hotel, French Lick, Ind.

Make Reservations Direct with the Hotel of Your Choice.

Yes: A Whale of a Convention Is in the Making



In the June issue of your JOURNAL we told of the many changes taking place at French Lick Springs Hotel in preparation for the "whale of a convention" of the Indiana State Medical Association, October 28, 29, and 30. We told you that this year it will be a full three-day meeting with many new and special features.

This is the Convention Arrangements Committee's second of a series of monthly broadcasts to give a preview of just how full this great three-day convention is going to be.

THE PROGRAM

THREE FULL DAYS OF UP-TO-THE-MINUTE SCIENTIFIC DISCUSSION, INSTRUCTION, AND EXHIBITS WITH PLEASING INTERLUDES SET IN A DELIGHTFUL ENVIRONMENT. AN EXTENSIVE POST-GRADUATE SEMINAR SO DIVERSIFIED TO INTEREST AND ENTHUSE EVERY GENERAL PRACTITIONER AND SPECIALIST IN THE STATE. A PERFECT BLEND OF STRAIGHT BONDED MEDICAL SCIENCE WITH JUST ENOUGH PURE GRAIN NEUTRAL SPIRITS OF FUN TO TAKE AWAY THE HEAVINESS.

Tuesday: The first day of this year's convention will not just be a golfing and hand-shaking day at French Lick. Medical Instructional Courses (presented for the first time at French Lick), will be the feature of the morning and afternoon scientific program. Of course, there will be the usual golf tournament and trap shoot with many attractive prizes. The special committees in charge of the features of the opening day program will have much to tell you later, so watch your JOURNAL.

INAUGURAL FROLIC TUESDAY NIGHT



This is something new on your state convention program. A joint frolic for the doctors, their wives, families and guests. Here we will loosen our girdles, sort of let our hair down and all get acquainted. Mom will not have to sit in her room and twiddle her thumbs while Pop goes to the Stag Party, for there won't be any Stag Party.

What's thrilling enough for Pop should be shocking enough for Mom—sez me. The frolic starts with the Tuesday evening dinner in the main dining room of the hotel. When the soup is served the fun begins, music and dancing, stunts, favors, prizes, floor show, in fact all the trimmings of a metropolitan play spot on New Year's Eve. The women won't bore'm but may add to the decorum. Need we say more?

Wednesday: The second day of the convention continues the association's quest for medical knowledge and the Indiana march of science, with a general scientific meeting in the forenoon and section meetings in the afternoon. Many nationally recognized medical leaders will address the general scientific meetings and the meetings of the sections on Surgery, Medicine, Anesthesia, General Practice, and Ophthalmology and Otolaryngology.

Wednesday evening has been set aside for fraternity and class dinners, servicemen's reunions, committee meetings, early-to-bed, or what's your pleasure?

Thursday: Here is a full day of scientific program added to your convention. Morning and afternoon General Scientific Meetings will feature some of the outstanding physicians of America, discussing the latest scientific developments in the medical field; a program especially prepared for and dedicated to the physicians of Indiana who really want to know "What's New in American Medicine."

ANNUAL BANQUET THURSDAY EVENING

Don't leave now. This is the annual feature of your state conventions. It is the one place you restore your decorum and strut your professional dignity. It is the one event "Mom" plans to proudly go with Papa. It makes no difference whether you wear your "nice blue suit" or appear in "tux and starch." The folks back home are going to be mighty disappointed in "Old Doc" if he doesn't stay for the grand finale. We believe we will have a program exceptionally worth while.

HOUSE OF DELEGATES AND COUNCIL

The members of the Council and the House of Delegates, those boys who do most of the work of the Convention and solve the many problems of Indiana medicine, are getting a break due to the full three-day session. The first council meeting will be scheduled for Tuesday afternoon, to be followed by the meeting of the House of Delegates.

Thursday, instead of the usual breakfast meeting at the barbarous hour of 7 A.M. (when the I.Q. is at the lowest point), they will be able to leisurely and intelligently convene their final meeting at the respectable hour of 11:30 A.M. The final meeting of the Council will immediately follow the Thursday meeting of the House of Delegates. In the meantime they may find time to attend a few scientific meetings and derive some personal benefits from the convention.

WATCH THIS SPACE

In the August issue of the JOURNAL we will broadcast some of the highlights and details of the scientific program and exhibits, which will feature this "Whale of a Convention in the Making."

In the meantime "Do not stand by. Make your hotel reservations today."

This is your clear channel station CAC (Convention Arrangements Committee) broadcasting on a frequency of once a month in your JOURNAL.

Clarence E. Boyd, Augustus P. Hauss, Co-chairmen, John K. Spears, Wm. H. Garner, E. P. Buckley, Samuel W. Baxter, Herbert P. Sloan, Mrs. James W. Baxter, Jr.

IN-PLANT INDUSTRIAL HEALTH PROGRAM

Louis W. Spolyar, M.D.*

INDIANAPOLIS

ANOTHER very effective county medical society in-plant industrial health program was held in Lake County when the Inland Steel Company was host to Lake County Medical Society. As part of their regular March meeting, Lake County physicians were conducted on an all-day plant-wide tour and in the evening the group was joined by top management at a dinner meeting. Through the efforts of Dr. E. H. Carleton, Medical Director of Inland Steel Company, and Dr. D. R. Johns, President, Lake County Medical Society, the physicians were exposed to all aspects of industrial medicine, its responsibilities, limitations and hopes. Similarly, through the plant tour, members of the medical group gained first hand visual information as to the type of work various men were doing, and how it was done.

Through this technique the physician accomplishes much in that he learns to appreciate what are the actual or potential occupational diseases that may be present in a given industry and, further, what controls and medical practices are being used to prevent this. Having this data the physician can better evaluate the complaints registered by the workers when such workers consult their private physicians on any health problem. Thus the chances of misdiagnosis, as far as occupational diseases are concerned, are tremendously lessened. This type of practice plus adherence to the Lake County code of ethics, delineating in a clear fashion the relationship between industrial and private physicians, will do much to further develop industrial medicine in Lake County. The code of ethics was formulated by the Lake County Medical Society through its committee on Industrial Health, headed by Dr. E. S. Jones of Hammond.

The Inland Steel meeting was well attended in that some two hundred participated in the day's activity. The company literally threw its doors open to the medical society and every member had free access to any part of the plant and could ask any questions. That the physicians did take this opportunity can be seen by reference to the photographs reproduced. Parties were shown through in small groups so as to "hear and see" more.

The evening dinner meeting was followed by a motion picture, "Drama of Steel." With this background plus the tours of the plant, Mr. A. J. Cochrane, of Inland Steel Company, discussed the development of the medical and safety programs. Again every effort was made to have everyone understand the medical problems associated with the manufacture of steel. I'm quite certain that everyone present was well informed and enlightened.

Such meetings deserve a great deal of consideration by other medical groups for problems in industrial medicine can be more readily appreciated when such problems are discussed and seen *in the plants* than if presentation is by the conventional hotel or hospital type of meeting. Further through the cooperation of industry and medicine, a mutual understanding of each other's problems will develop that will be beneficial to both groups embracing all phases of industrial medicine. Congratulations, Inland Steel, and Lake County Medical Society for a job well done.

* Director, Division of Industrial Hygiene, Indiana State Board of Health.

Figure 1





Above. Dr. E. S. Jones, Mr. A. J. Cochrane, Dr. E. H. Carleton, Dr. D. R. Johns.

Left, group of physicians viewing operations on the open hearth floor.

Right, Lake County Medical Society members visiting the blast furnace department.



INDIANA'S HOSPITAL PLAN

MARTHA O'MALLEY, M.D.*

INDIANAPOLIS

* Director, Division of Hospital and Institutional Services, Indiana State Board of Health

THE Indiana State Board of Health was directed by an act[1] passed by the 1945 Indiana General Assembly to make a survey of hospitals and health centers, evaluate their sufficiency, compile data and conclusions, together with a statement of the additional facilities necessary in conjunction with existing structures, to supply the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all the people of the state.

In addition to the State Hospital Survey Act, the Federal Hospital Survey and Construction (Hill-Burton Bill) Act[2] was passed by the 79th Congress and signed by President Truman on August 13, 1946. This bill, while it was under consideration by Congress, was generally supported by medical, hospital, dental, public health, agriculture, industry and labor associations and groups. At the insistence of professional groups the bill[3] contained the following general principles:

"First, that any hospital or other health facilities constructed with federal aid be planned as part of a long range health development and not as incidental to a public works program; second, that no federal funds should go into any health facilities until the need has been demonstrated by a careful survey; third, that construction shall be controlled through an agency of the state and not by direct federal-local negotiation; fourth, that voluntary nonprofit hospitals, as well as state, county, and municipal hospitals shall be eligible for assistance; fifth, that the principle of states' rights and local initiative be preserved and encouraged as essential to the success of any health program."

These principles are incorporated in the Hospital Survey and Construction Act, Public Law 725. The purpose of this act is to assist states to survey their needs for additional hospital and health facilities, and grant federal funds to aid in the construction of hospitals and health centers in accordance with the over-all state plan. The federal administration of the act is under the United States Public Health Service. The state administration of the program may be under the state health agency or any other designated state agency. The act allows for one state agency to administer the survey and planning program and another agency to administer the construction program, or the same agency can administer both. The act authorized for survey and planning purposes an appropriation of $3,000,000. Of this amount $1,500,000 was appropriated by the 79th Congress for the fiscal year 1947. In addition to survey and planning, this act authorized for the construction of hospitals and allied facilities an appropriation of $75,000,000 for the fiscal year ending June 30, 1947, and for each of the four succeeding fiscal years.

Before any state is eligible to receive federal funds for hospital construction a state plan based upon a survey, and in accordance with federal rules and regulations, must be made and approved by the Surgeon General and the Federal Hospital Council. As prescribed in the act, the federal regulations for the development of the state plan were distributed to the states during February, 1947, within six months after Public Law 725 was enacted.

The State Board of Health completed the survey of hospitals and health centers early in 1946 and with the assistance of an Advisory Hospital and Health Center Planning Council has developed a State Hospital Plan which conforms to both state and federal legislation. The plan designates base, intermediate, and rural hospital service areas. It lists the number and location of new and additional general, chronic diseases, mental, and tuberculosis hospital beds, as well as public health units. The number of hospital beds of the various categories was determined by federal law and regulations, in the following manner:

1. A total of 4.5 general hospital beds per 1,000 population of the state. These were allotted on the basis of a minimum of 4.5 per 1,000 in the base area, 4 per 1,000 in intermediate areas, and 2.5 per 1,000 in rural areas.

2. A total of 2.0 chronic disease beds per 1,000 population of the state. In the Indiana Plan 1.5 chronic disease beds per 1,000 population were allotted to local (rural) hospitals, and the remaining beds, amounting to over 2.0 per 1,000 population were planned in intermediate and base areas.

3. A total of 5 mental beds per 1,000 population of the state. In Indiana, one-third of the total mental beds were planned as units of intermediate and base hospitals, and the other two-thirds were planned in state mental hospitals.

4. In contrast to other hospital facilities tuberculosis beds are planned on the basis of the death rate rather than on the basis of population. The

1. *Hospital Survey Act,* Chapter 101, Acts of the Indiana General Assembly, 1945.

2. *The Hospital Survey and Construction Act,* Public Law 725, 79th Congress, U. S. Government Printing Office.

3. *Hearings on Hill-Burton Bill,* United States Senate Committee on Education and Labor, United States Government Printing Office, 1945.

maximum ratio of tuberculosis beds is two and a half times the average annual deaths from tuberculosis. Tuberculosis units are indicated in the plan in connection with intermediate and base hospitals as well as in county and state tuberculosis sanitoriums. Tuberculosis and mental units can be planned as units of general hospitals in other than the intermediate and base areas, provided trained medical, nursing, and other personnel can be secured to staff them.

The State Hospital Plan also provides for public health units. The development of Public Health Centers with administrative offices for public health personnel is contingent upon the development of full-time health units. These administrative units may be planned in connection with hospitals or health centers or may be completely separate facilities. Using the proposals of Dr. Haven Emerson as a guide, thirty-six public health units are suggested for Indiana.

Indiana's Hospital Plan proposes an alignment of hospitals on a regional basis according to a coordinated hospital system. This system allots additional beds to those centers designated as base and intermediate areas on the thesis that they will provide consulation, specialized patient care, research and educational services to the rural hospitals and health centers. The plan proposes only a framework for the development of a coordinated hospital program. Its actual development and functioning are dependent on Indiana's Medical Society, Hospital Association, Dental Society, Nursing Association, Mental Health Council, Tuberculosis Association, and other professional groups and persons.

Fig. 1

COORDINATED HOSPITAL SYSTEM FOR INDIANA



According to Indiana's Coordinated Hospital Plan (Fig. 1), Indianapolis is designated as the base area; Evansville, New Albany, Terre Haute, Muncie, Lafayette, Fort Wayne, Gary, and South Bend are designated as intermediate areas. Potential intermediate areas are: Bloomington, Columbus, Princeton, Vincennes, Washington, Bedford, Kokomo, Anderson, New Castle, Richmond, Marion, Crawfordsville, Logansport, Michigan City and Elkhart. All areas other than intermediate or base areas are designated as rural areas with hospital or health center facilities.

The Base Area includes a teaching hospital of a medical school approved by the American Medical Association Council on Medical Education and Hospitals. In the coordinated hospital plan it is expected that this area will provide services in the various medical specialties, will make available consultation service to district and rural hospitals, will carry on undergraduate and postgraduate educational programs for professional personnel, and will conduct research investigations in one or more departments.

The characteristics of the district hospital in the intermediate hospital areas, according to the State Hospital plan, are as follows: possess a hospital that meets equivalent requirements of the American College of Surgeons and the Educational Council of the American Medical Association, one that maintains high quality facilities and personnel for providing specialized service in the following fields: internal medicine, major surgery, obstetrics, pediatrics, ear, nose and throat, dentistry, radiology, pathology, bacteriology and chemistry, and has plans for offering specialized services in ven-

ereal disease, tuberculosis, communicable disease and psychiatry. In addition, the district hospital will provide training courses for interns or general residencies, and in co-operation with the base hospital, provide post-graduate educational opportunities for professional personnel in the area.

The Indiana State Hospital Plan establishes the priority for federal grants-in-aid for hospital construction for each hospital service area in the state. The primary factor considered in determining priorities was the relative need for hospital services. Factors considered in addition to relative need were distance from existing hospitals and the community's effective buying power in relation to that of the state. For priority listing of hospital service areas see Tables I, II, III, and IV.

Indiana's Hospital Plan has been approved by the Advisory Hospital and Health Center Planning Council and by the State Board of Health. It has been approved in principle by the executive committee of the Indiana Medical Association and the Indiana Hospital Association. In addition, it was presented to the state and component offices of the State Dental Society, to the Indiana Society of Architects, and to the Indiana Economic Council. The plan was publicized in newspapers throughout the state and a public hearing was held on the plan June 9, 1947, at the State Board of Health building. The plan will be submitted later this month to the Surgeon General of the United States Public Health Service for his approval. Following the approval of the plan by the Surgeon General, Indiana will be eligible to receive federal funds for hospital construction as soon as they are available. Funds have been authorized under the Federal Hospital Survey and Construction Act but have not been appropriated as yet.

The Hospital Construction Program will be developed in accordance with the State Hospital Plan and will be under the administrative direction and supervision of the State Board of Health. The 1947 Indiana General Assembly enacted legislation[4] authorizing the State Board of Health to co-operate with the government of the United States in the construction or improvement of public and other non-profit hospitals and to accept and disburse federal funds to carry out this work.

4. *Hospital Survey and Construction Act*, Acts of the Indiana General Assembly, 1947.

TABLE I

Area No.	County	Hospital Community Area Center	Area Priority No. "A"	% of Need Met	Miles to General Hospital	Area Rank* Financial Need
R-21	Perry	Tell City	1	0	46-50	84
R-27	Washington Scott	Salem	2	0	30-35	85
R-57	Lagrange	Lagrange	3	0	"	67
R-60	Starke	Knox	4	0	20-25	75
R- 8	Hendricks	Danville	5	0	"	68
R-47	Pulaski	Winamac	6	0	"	59
R- 2	Tipton	Tipton	7	0	"	48
R- 9	Hancock	Greenfield	8	0	"	37
R-42	Fountain Warren	Veedersburg Williamsport	9	0	"	34
R-14	Rush	Rushville	10	0	"	32
R-54	Whitley	Columbia City	11	0	"	29
R-20	Warrick Spencer	Boonville	12	0	15-19	81
R-10	Owen	Spencer	13	0	"	70
R-19	Dearborn Ohio	Lawrenceburg	14	0	"	45
R-46	Jasper Newton	Rensselaer	15	0z		55
R-37	Randolph	Winchester	16	0z		27
R- 4	Hamilton	Noblesville	17	0z		43
R-24	Knox	Vincennes	18	0z		24
R-23	Dubois	Jasper	19	Less than 25%		77
R-31	Greene	Linton	20	"		59
I- 2	Floyd Clark Crawford Harrison	New Albany	21	"		55
R-55	Noble	Kendallville	22	"		23
I- 1	Vanderburgh Posey	Evansville	23	"		3

* Ranks are arranged in inverse order. Areas needing financial assistance must have the highest numerical rank.

z County has non-conforming general hospital. These four counties are arranged in order of relative need considering existing facilities.

Cities and towns listed under this heading are the name by which the area will be known. Several hospitals and health centers may be located in each area designated.

TABLE II

Area No.	County	Hospital Community Area Center	Area Priority No. "B"	% of Need Met	Area Rank Financial Need
R-26	Lawrence Orange	Bedford	24	25-30	51
R-56	Dekalb	Auburn	25	"	32
R-61	Marshall	Plymouth	26	"	27
R-36	Wayne	Richmond	27	"	9
R-22	Gibson Pike	Princeton	28	31-35	68
R-11	Morgan	Martinsville	29	"	59
R-48	Fulton	Rochester	30	"	24
R-58	Steuben	Angola	31	"	9
R-40	Jay	Portland	32	36-40	57
R-33	Vermillion	Clinton	33	"	45
I- 4	Delaware	Muncie	34	"	17
R-43	Clinton Parke	Frankfort	35	"	13
I- 3	Vigo	Terre Haute	36	"	5
R-38	Grant	Marion	37	41-45	19
R-44	Cass Carroll	Logansport	38	"	19
R-64	Elkhart	Elkhart	39	"	12
I- 8	St. Joseph	South Bend	40	"	7
I- 5	Tippecanoe White Benton	Lafayette	41	"	4
I- 6	Allen	Fort Wayne	42	41-45	2
R-25	Daviess Martin	Washington	43	46-49	70
R-29	Jackson	Seymour	44	"	51
R-32	Clay	Brazil	45	"	51
R-34	Fayette Union Franklin	Connersville	46	"	42
R-50	Huntington	Huntington	47	"	14

TABLE III

Area No.	County	Hospital Community Area Center	Area Priority No. "C"	% of Need Met	Area Rank Financial Need
R-62	LaPorte	Michigan City	48	50-55	29
R-15	Monroe Brown	Bloomington	49	"	26
R-13	Shelby	Shelbyville	50	"	14
R-28	Jefferson Switzerland	Madison	51	56-60	62
R-16	Bartholomew	Columbus	52	"	51
R-59	Porter	Valparaiso	53	"	37
R-53	Kosciusko	Warsaw	54	61-65	41
R-39	Blackford	Hartford City	55	"	9
I- 7	Lake	Gary	56	"	6
R-30	Sullivan	Sullivan	57	66-70	64
R-17	Decatur	Greensburg	58	"	48
R- 7	Putnam	Greencastle	59	"	44
R-35	Henry	New Castle	60	"	34
R- 6	Madison	Anderson	61	66-70	21
R-49	Wabash	Wabash	62	"	17
R- 1	Marion	Indianapolis	63	"	1
R-51	Wells	Bluffton	64	71-74	66
R-45	Miami	Peru	65	"	22
R- 1	Howard	Kokomo	66	"	14

TABLE IV

Area No.	County	Hospital Community Area Center	Area Priority No. "D"	% of Need Met	Area Rank Financial Need
R-52	Adams	Decatur	67	75-80	74
R-41	Montgomery	Crawfordsville	68	"	8
R-18	Ripley	Batesville	69	81-90	48
R-12	Johnson	Franklin	70	Over 90	62
R- 3	Boone	Lebanon	71	"	45
R-63	LaPorte	LaPorte	72	"	29
R- 5	Madison	Elwood	73	"	21

BOND-A-MONTH PLAN

THE Bond-A-Month Plan is being offered by banks to their depositors for the systematic purchase of U. S. Savings Bonds. This plan will be put in operation throughout the United States in a June and July promotion period to increase the sale of savings bonds.

Economists are in full agreement that to manage the national debt *wisely* we must spread it *widely* among individual investors. Every professional study made of the public debt problem has come to that conclusion.

There are two main channels through which we are now working to spread the debt: (1) the Payroll Savings Plan for the regular sale of U. S. Savings Bonds to wage and salary earners in business and industry, and, (2) sale of savings bonds by banks to those to whom Payroll Savings is not available where they work—to farmers, small business firms, professional people and others who are self-employed.

Most professional men and owners of businesses have no social security or pension plan to fall back on. They need something to serve as an old age reserve. A savings bond plan should be the foundation upon which to build such a reserve. There is no safer investment in the world than savings bonds. There is no riskless investment which pays such a guaranteed return.

Professional men haven't time to thoroughly investigate before making an investment. They are scientists, analysts of human ailments, artists of the operating room, travellers in the night, worriers, dreamers and curers, but not financiers.

Here is offered an easy and simple plan to create an annuity, or to build a financial reserve. All you need do is to sign an authorization card at your bank, authorizing the bank to charge your checking account each month with the full purchase price of a bond or bonds as you and your banker may determine. Your bonds will then be delivered to you regularly each month. There is no chance of business pressure causing you to slip up on the bonds you intended to buy.

If you invest monthly under Bond-a-Month Plan in E Bonds	In five years you will have	In ten years you will have
$ 37.50	$ 2,319.00	$ 4,998.00
75.00	4,638.00	9,996.00
150.00	9,276.00	19,992.00
300.00	18,552.00	39,984.00

Too often the value of systematic savings and interest accrual is not appreciated. For example: if a man signs up on the Bond-A-Month Plan and invests $75.00 per month in E Bonds, and continues investing interest accruals over a thirty-year period, he can then discontinue buying and will be assured of an income of $411.11 per month for the next ten years. In other words, a $27,000 investment over a period of 30 years, returns to the investor the sum of $49,333.20. The interest on the funds invested amounts to $22,333.20.

Your individual economic security depends upon the economic stability of our government. If you invest regularly in U. S. Savings Bonds you will not only have accumulated a financial reserve, but by helping to spread the national debt you will have contributed to the economic stability of our government.

Medical Panorama by the Associate Editor

MULTNOMAH COUNTY (Oregon) objects strenuously, in the public interest, to rent increases of 64.5 per cent over 1944 for medical and dental office space. Such "inflationary and unjustified" measures can only be reflected in an increase in the cost of medical care.

———— S IAM ————

ERIE COUNTY (New York) indicates a determined resistance to the United States Veterans Administration's plan to set up a single, nationwide fee schedule for community medical care of veterans. They believe the proposal to be "unsound and impractical in principle and substance and would interfere with, if not definitely lower, the high quality of medical care now being rendered veterans by physicians of this state. . . ." The national fee schedule is proposed on the theory that it would "achieve uniformity and expedite negotiations between the Veterans Administration and Medical service organizations concerning fee schedules."

———— S IAM ————

DETROIT Medical News scores the implication that medical or surgical care is often unobtainable because of inability to pay a fee. In part:

"We, as a group, represent a cross-section of the population in race, creed, and color. We come from all walks of life and most of us are attracted to medicine in our youth, driven by the urge to do something for humanity. Hence, we are apt to have at least as deep a sense of humanitarianism as the population from which we are drawn—even though humanitarianism is our daily business. What we mean to say is that we are human beings first and physicians second. We are subject to the reactions of happiness and sorrow, love and hate, greed and generosity, and all the emotions with which other folks are blessed or cursed. We go to the movies, play the horses, go to church, wear underwear, use hair tonic, break the Commandments, eat whole wheat bread, and sometimes take vitamins. We even help our wives with the dishes. We have one advantage and privilege over our brothers; we get to know human beings and, in spite of it, most of us remain chronic incurable idealists. We have never in our time known of a worthy person denied help because of lack of money. We have known of many chiselers who whined when they were refused free services. The breast of the medico is just as full of the milk of human kindness as any other group—professional or profane—and you can say that again."

NEW YORK will honor member physicians who have practiced fifty years or more at their coming annual meeting. A suitable certificate, signed by the president and secretary, will be presented with appropriate ceremonies.

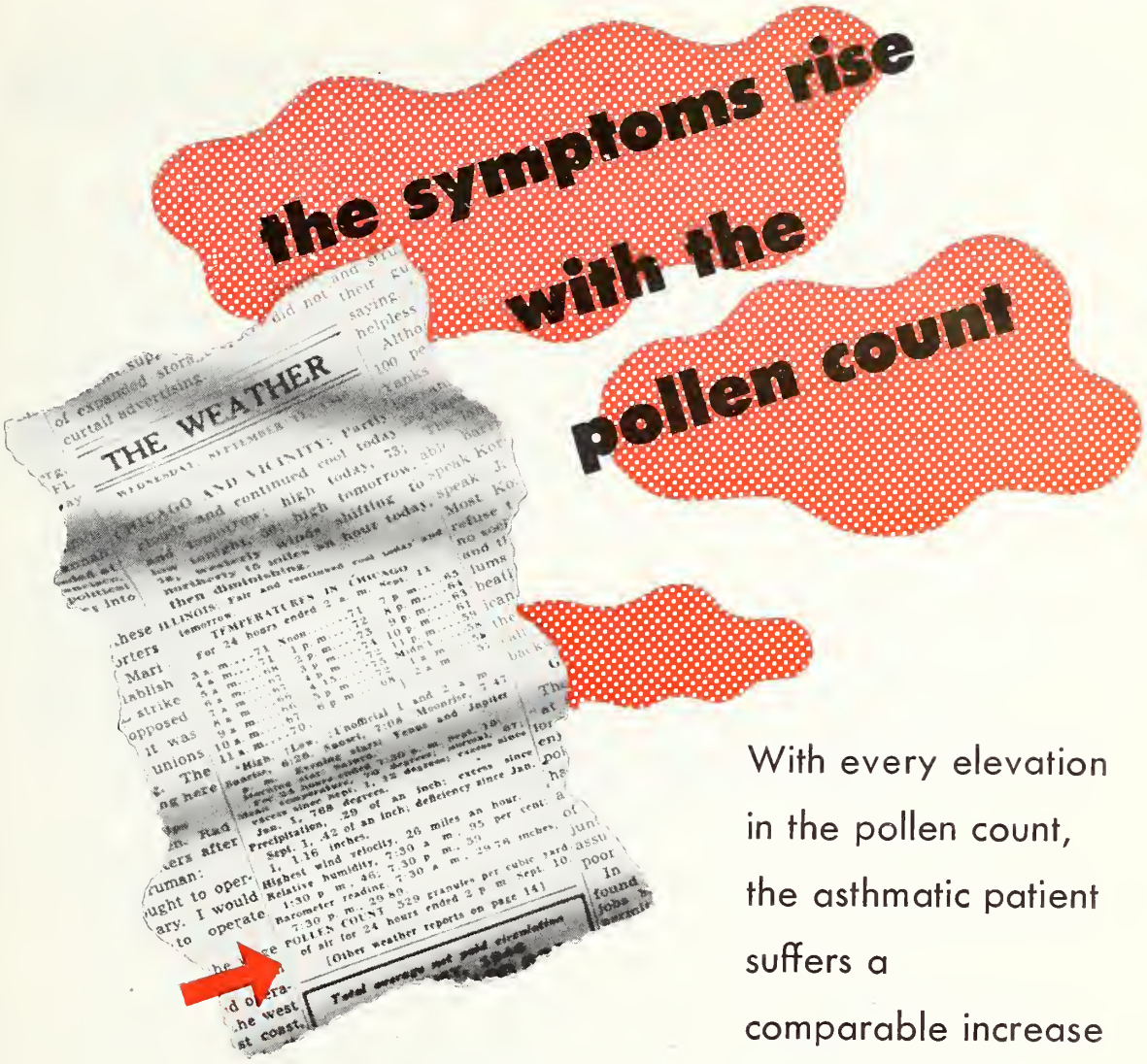
———— S IAM ————

TOLEDO (Ohio) admonishes the physician to get his house in order for the recession that "is in the air." Warning is given that a self-inventory is in order both as to character of services rendered and collection of accounts. Most business advisory services are indicating that this recession will hit full stride this summer and extend well through 1948.

———— S IAM ————

NEW JERSEY makes an eloquent statement with reference to the pharmacist as follows:

"One of the physician's quietest and hardest-working allies is the pharmacist. He imprisons himself in his little store; receives an occasional, and too often patronizing nod from the passing physician; and tries with unending patience to serve the foibles of a hundred citizens who cross his threshold every day. All he asks of the doctor is some token of recognition that pharmacy is an ancient, scholarly, and honorable profession; that sometimes he be given a chance to practice that profession instead of being considered a mechanical transmitter of packaged merchandise; and, also please, that prescriptions be written a little more legibly. He hopes you won't put him on the spot by asking him over the phone to fill an oral narcotic prescription, and he asks that you respect his right to evaluate his own professional fees, as he respects yours. That really isn't asking too much. In return he is in a position to radiate neighborhood good will towards your office, to procure somehow even the newest drug that the detail man has just extolled, to suggest a pleasant and compatible vehicle for a seldom-used medication, and once in a while to correct those little clerical errors that we all sometimes make on a prescription blank. An occasional visit with the corner pharmacist is worth any doctor's while. So is a joint meeting between the medical and pharmaceutical societies. We are brethren in the healing art. And brothers should know each other better."



With every elevation in the pollen count, the asthmatic patient suffers a comparable increase in the severity of symptoms. In the dyspnea of allergic asthma, Aminophyllin has been found to provide efficient relief.

AMINOPHYLLIN

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Searle Aminophyllin contains
at least 80% of anhydrous theophylline.
G. D. Searle & Co., Chicago 80, Illinois

SEARLE

RESEARCH
IN THE SERVICE
OF MEDICINE

What's Going On In Indiana by the Executive Secretary

Membership at New High. Membership of the Indiana State Medical Association on June 1, 1947, was 3,507. This is the highest in the ninety-eight years of medical association history. By the year's end the figure may reach 3,550. Of interest is the fact that the membership is 155 more than June 1, 1946, and 312 more than June 1, 1945. These figures show the steady improvement in medical services in Indiana. Statistics from the American Medical Association reveal that there were 6,959 additions to the medical profession in the United States in 1946. Death removed 3,358, making an increase of 3,601 in physician population.

——ISMA——

New Dean of Medical School. Thirty-nine-year-old Dr. John D. Van Nuys was selected by the board of trustees of Indiana University as dean of the Indiana University School of Medicine. He succeeds Dr. W. D. Gatch, who resigned as dean a year ago. Dr. Van Nuys is the son of Dr. W. C. Van Nuys, superintendent of the Indiana Village for Epileptics at New Castle, and has been a member of the Indiana University Medical Center staff since 1937. His appointment came after more than 200 persons were considered, and after extensive interviewing and consultations of medical school alumni by President Herman B Wells of the University. For five years Dr. Van Nuys was medical director of the university hospitals. When informed of his appointment, Dr. Van Nuys said, in part: "I consider it a special privilege to assume the leadership of my own school and will conduct its management in the interest of the people of the state of Indiana, the medical profession and the university."

——ISMA——

Woman's Auxiliary Expands. The Woman's Auxiliary, with a membership of more than 1,300, has set 2,000 as its goal for 1947-48. With membership of the Indiana State Medical Association exceeding 3,500, this does not seem an unreasonable figure. Physicians should encourage their wives to join the Auxiliary, and county medical societies without Auxiliary units should take the leadership in organizing them. Who should be any more interested in good things for medicine than physicians' wives? The influence of the women in their communities, through their numerous and various activities, should not be underestimated. Well organized and well directed, they are valuable partners. The state Auxiliary officers soon will begin issuing a bulletin for circulation to members and non-members, and with co-operation from the physicians themselves, the Indiana Woman's Auxiliary will become the pace setter among all the states.

Mooreland Gets a Doctor. Mooreland, a small town (496 souls by 1940 census) northeast of New Castle, in Henry County, has not had a doctor for several years. The community decided to do something about it. A committee was organized, chairmanned by the cashier of the bank. The first thing the committee did, knowing a doctor would need a place to live, was to lease a nice home for him. As for getting an office, the committee decided the doctor would have his own ideas about that, so this was held in abeyance. The committee did decide to give financial help to the doctor, if he needed it. With this definite program the committee started out to find a well-trained physician who wanted to locate in a rural community. Through proper channels the "Get a Doctor for Mooreland" committee contacted a number of prospects and came to terms with one of them. A small house just off the principal street was purchased and converted into an office. The doctor is now busy caring for the sick. On June 30 a dinner was given in his honor, to "introduce" him to the community. Mooreland has set a good example for other towns short a doctor.

——ISMA——

Post-Graduate Courses. Surveys, usually through advertising agencies, is the instrument used by business to get a check upon its market; in other words, to learn what the people want and will buy. This same technic was employed by the Committee on Public Relations when the Council assigned it the job of sponsoring post-graduate courses. First, the committee asked in letters to county and district medical societies, is there a desire for such courses. The second question was, if in favor, where they should be held—at Indianapolis, at some central point in the district, or at a regular meeting of the county medical society. The replies to the questionnaire are very interesting. As of this writing forty-one answers had been received. Thirty-five expressed a desire for the educational courses, and six were to the contrary. Only five wanted them held in Indianapolis. Twenty wanted the post-graduate courses given at some city in the district, and the others are for them at the county level, or did not indicate a preference. Holding these scientific lectures and discussions is unquestionably good public relations. Physicians will be equipping themselves to do better medicine. The public will be impressed.



WINTHROP

Demerol hydrochloride ranks between morphine and codeine in analgesic power. Furthermore, it possesses marked spasmolytic and mild sedative action. It causes less nausea and vomiting and less urinary retention than morphine, and no constipation. The danger of respiratory depression is also greatly reduced with Demerol hydrochloride. Warning: May be habit forming. Ampuls of 2 cc. (100 mg.) and tablets of 50 mg. Narcotic blank required.

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News Notes

Announcement has been made by Dr. William S. Oliver, formerly of Cleveland, Ohio, of his association with Dr. Oran A. Province and Dr. William Province, of Franklin, in the practice of medicine and surgery.

Dr. W. C. Polhemus has opened an office for the general practice of medicine at 1803 Pearl Street, Anderson.

Announcement has been made of the marriage of Dr. Richard Russell, of Indianapolis, and Miss Lynn Martin, of St. Louis, on May eighteenth, in Indianapolis. Dr. and Mrs. Russell have established their residence at 625 East 25th Street, Indianapolis. Dr. Russell is resident anesthetist at the Indianapolis City Hospital.

Miss Doris E. Wheeler and Dr. Fred L. Toumey were united in marriage on May seventh, at the Central Christian Church, in Indianapolis. Dr. and Mrs. Toumey will reside in Indianapolis as Dr. Toumey is a resident physician at the Indiana University Medical Center, and Mrs. Toumey is supervisor of the Cerebral Palsy Clinic at the James Whitcomb Riley Memorial Hospital.

Dr. Charles E. Walters has announced the opening of an office at 114 Lincoln Way West, Mishawaka, for the practice of general surgery.

Dr. Clifford A. Wiethoff, who has completed a one-year residency in pathology at the Indiana University Medical Center, has received an appointment to a residency in surgery at the Indianapolis City Hospital.

Dr. Steven J. Rudolph has opened an office at 1638 North Meridian Street, Indianapolis, for the practice of obstetrics and gynecology. Doctor Rudolph has completed residencies in obstetrics and gynecology at Coleman Hospital, in Indianapolis, and the Philadelphia Lying-In Hospital.

Dr. C. O. McCormick, of Indianapolis, is attending a meeting of the International Congress of Obstetricians at the Rotunda Hospital, in Dublin, Ireland. The meeting is in observance of the 200th anniversary of the founding of Rotunda Hospital, which is one of the world's most noted maternity hospitals. Dr. and Mrs. McCormick and their son are visiting in London, Paris, and Amsterdam while abroad.

Announcement has been made by Dr. Norman E. Beaver of the opening of an office in Berne for the general practice of medicine.

Dr. Robert D. Berke and Dr. Morris S. Friedman, veterans of World War II, have opened an office for the practice of medicine at 114 Lincoln Way West, Mishawaka.

Dr. J. W. Bowers, of Fort Wayne, has been awarded a citation for outstanding work beyond the call of duty from the surgeon general of the U. S. Army for his work at the Mayo General Hospital, Galesburg, Illinois, where he served as executive and commanding officer during a period of expansion from 1,339 to 2,500 beds and for duty with the Northwest Division as district surgeon in command of three hospitals and thirty-two stations in the northwest area of the nation.

Dr. William A. Clunie, of Corydon, a former Army medical officer, has gone to Chicago where he will be resident surgeon in the Chicago Eye, Ear and Throat Hospital.

Announcement has been made by Dr. Robert Bryan, formerly of Indianapolis, that he has opened an office for the practice of medicine at 129 North Main Street, Kendallville.

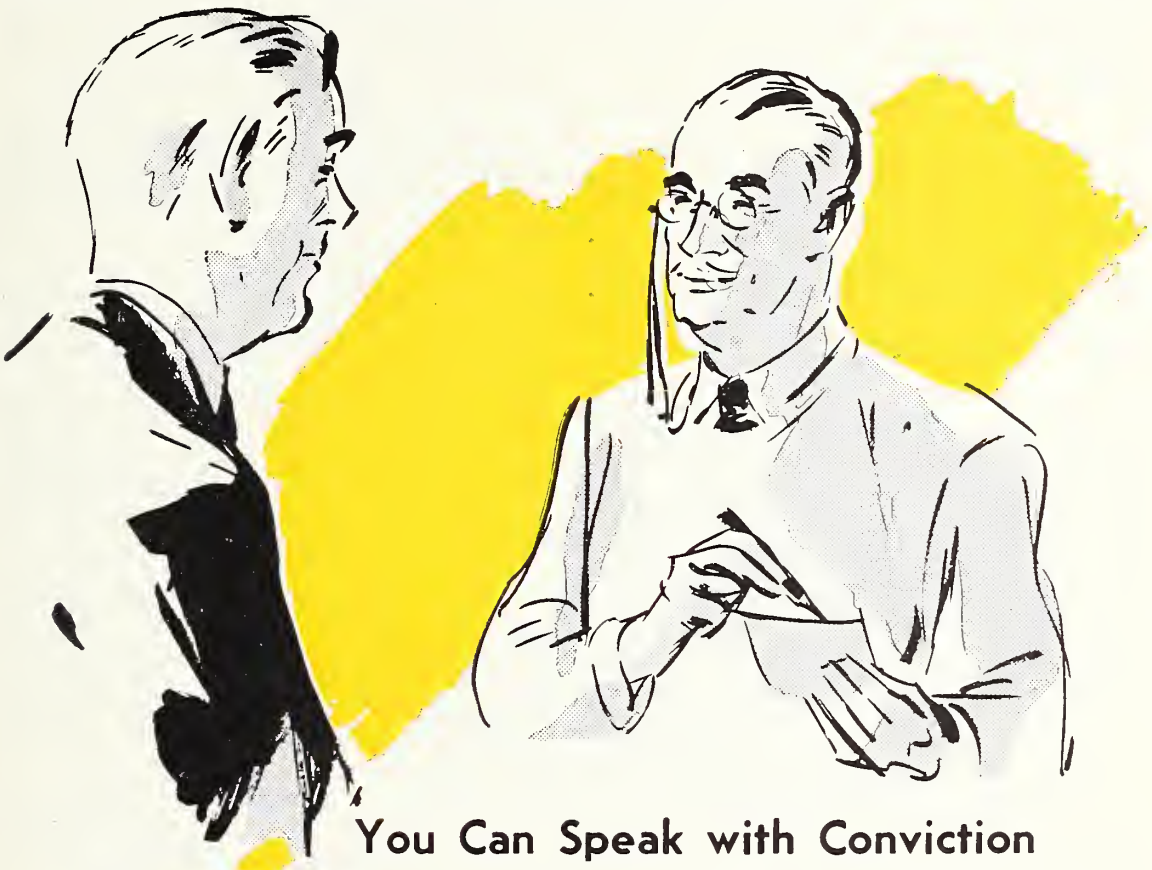
Dr. Hugh W. Eikenberry, of Indianapolis, and Dr. Paul R. Tindall, of Shelbyville, have been reappointed to the State Board of Medical Examination and Registration by Governor Ralph F. Gates.

THE JOURNAL wishes to congratulate Dr. Charles H. Emery, of Bedford, who has recently completed fifty-five years in the practice of medicine in Bedford.

Dr. Robert L. Gammieri has opened an office for the practice of medicine at 3326 Clifton Street, in Indianapolis.

The twelfth Assembly and Convocation of the United States Chapter of the International College of Surgeons will be held at the Palmer House, in Chicago, September 28, 29, 30, and October 1, 2, 3, and 4.

Dr. Dean Jackson, formerly of Angola, has become associated in the practice of medicine with Dr. J. W. Morris, of Muncie.



You Can Speak with Conviction When You Choose Dorsey

Constantly aware of the responsibility to your patient, your profession and yourself, you and every careful physician will think twice--or a dozen times--before prescribing the products of a given pharmaceutical manufacturer.

When you do name a manufacturer, you speak with conviction.

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SOLUTION OF ESTROGENIC SUBSTANCES-DORSEY

Dorsey

Dr. Theodore O. Meyer has announced the opening of an office at 335 Lincoln Tower, Fort Wayne, for the practice of ophthalmology.

Dr. A. Jerome Sparks, formerly of Fort Wayne, has informed THE JOURNAL office that he is now the urologist at the Veterans Administration Hospital in Alexandria, Louisiana. Doctor Sparks reports that he is happy to be relieved of the duties of private practice, which he had done for approximately thirty years. His address is 127 Marigold Drive, Alexandria, Louisiana.

A regional meeting of the College of American Pathologists was held at Indiana University Medical Center, Indianapolis, April 7, 1947. The states represented were Ohio, Michigan, Illinois and Indiana, with an attendance of about one hundred and twenty-five pathologists. Dr. F. W. Hartman, Henry Ford Hospital, Detroit, President of the College of American Pathologists, presided. The meeting was devoted to discussions of various aspects of hematology.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

The American Congress of Physical Medicine will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6, inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 2, 3, 4 and 5. These courses will be open to physicians and the therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

CENTRAL STATE HOSPITAL REPRESENTED AT CENTENNIAL MEETING

Dr. Max A. Bahr and Dr. Walter L. Bruetsch of the Central State Hospital, of Indianapolis, were represented with a scientific exhibit entitled "Optic Nerve Atrophies," at the Centennial Meeting of the American Medical Association, Atlantic City, June 9th inclusive of 13th.

Dr. Walter L. Bruetsch addressed the Section on Ophthalmology of the American Medical Association on "Unilateral Syphilitic Optic Atrophy."

At the annual meeting of the American Neurological Association, held in Atlantic City, June 16th inclusive of 18th, Dr. Walter L. Bruetsch read a paper on "Optic Atrophy in Pick's Disease."

Dr. Frederick L. Kuhn has announced the opening of offices at 1215 South Michigan Street, South Bend, where he will practice general medicine.

Dr. Eugene F. Kratzer, of Kokomo, has resumed the practice of medicine, after nearly a year and a half of illness during which time his office was closed.

The annual meeting of the Indiana Roentgen Society was held on Sunday, May 18th, 1947, at 2:00 P. M., at the Indianapolis Athletic Club. Forty-eight members attended.

At the afternoon business meeting the following officers were elected: Dr. Harold C. Ochsner of Indianapolis, president; Dr. G. H. Wisener of Richmond, vice-president; Dr. John A. Campbell of Indianapolis, secretary-treasurer; and Dr. Lester G. Erickson of South Bend, state councilor to the American College of Radiology.

Following an evening dinner, Dr. Wendell G. Scott of Washington University, St. Louis, Missouri, delivered a most interesting discussion, illustrated by lantern slides and colored movies, on "Radiographic Diagnosis of Prolapsed Redundant Gastric Mucosa into the Duodenum: Its Clinical Significance and Treatment."

PLANS FOR NEW STATE BOARD OF HEALTH BUILDING APPROVED

Preliminary plans for a new State Board of Health building were approved by the State Board of Health at a meeting May fifteenth in the Medical Center.

A four-story structure, the new building will supply the State Board of Health with laboratory and office space and facilities to carry out the expanded public health program authorized by the last two sessions of the General Assembly.

The present quarters of the Board of Health will be turned over to the Indiana University School of Medicine to house its laboratories and administrative offices.

One of the outstanding features of the new building will be the steel and glass removable partitions in the laboratories. These will be sectionalized and will provide a greater degree of safety where work is done in connection with highly infectious diseases by making each unit self-sustaining and easily separated from other activities.

"The new building," stated Doctor Burney, "is so designed as to be easily adaptable to future needs in public health. Needs for health facilities change as methods and techniques change."

Plans for the building include a full basement for storage and maintenance shops and an auditorium with 130 fixed seats and additional space for temporary seats and exhibits.

It is expected that final plans and specifications will be ready for construction bids sometime this coming fall.

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And first in the list of offending foods is *milk*... milk, that most vital constituent in all infants' and children's diets!

• Fortunately, milk can be replaced with MULL-SOY, a hypoallergenic soy food possessing the essential nutritional values of cow's milk, but free from offending animal proteins.

• MULL-SOY is a biologically complete vegetable source of all essential amino acids, and approximates cow's milk in its percentages of protein, carbohydrate, fat and mineral content when mixed with water in standard dilution (1:1). Infants (as well as children and adults) find MULL-SOY palatable, easy to digest, and well tolerated. It is simple to prepare.

*Levine, S. Z.: J.A.M.A. 128:283, May 26, 1945

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ACCEPTED AMERICAN MEDICAL ASSN.

MULL-SOY is a liquid emulsified food prepared from water, soy flour, soy oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and soy lecithin; homogenized and sterilized. Available in 15½ fl. oz. cans at all drug stores.

Deaths

Edward G. Lukemeyer, M.D., of Huntingburg, died on May twenty-sixth at his home, following a brief illness. He was eighty-seven years of age. Doctor Lukemeyer graduated from the Louisville Medical College in 1885 and for over half a century had been practicing medicine in the vicinity of Huntingburg. He was an honorary member of the Dubois County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

Harry M. Pell, M.D., of Brazil, died on May thirty-first, at the age of fifty-seven years. Doctor Pell was graduated from the Indiana University School of Medicine, in Indianapolis, in 1912 and had practiced medicine in Brazil for thirty-four years. He served in World War I as first lieutenant in the Medical Corps. Doctor Pell was a member of the Clay County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

George W. Boner, M.D., of North Madison, died suddenly at his home, on May thirtieth, at the age of sixty-nine years. Doctor Boner graduated from the Hospital College of Medicine, in Louisville, in 1906. He was a captain in the Medical Corps in World War I. In July, 1945, Doctor Pell received the appointment as superintendent of the Madison State Hospital. He was a member of the Jefferson County Medical Society, the Indiana State Medical Association and the American Medical Association.

* * *

James L. Wilson, M.D., of South Bend, died on May eleventh, following a short illness. He was sixty-two years of age. Doctor Wilson graduated from the Rush Medical College, in Chicago, in 1912. He was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, the American College of Surgeons, and a Fellow of the American Medical Association.

* * *

Earl R. Gibbs, M.D., of Wilkinson, died on May thirteenth, following an extended illness. He was sixty-six years of age. Doctor Gibbs graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1907. He was a veteran of World War I having served in the United States Army Medical Corps. He was a member of the Hancock County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

Heilman C. Wadsworth, M.D., of Washington, died at his home on June sixth, at the age of sixty-eight, following a long illness. He was a graduate of Rush Medical College, in Chicago, in 1909, and had practiced medicine and surgery in Washington for thirty-five years.



H. C. Wadsworth, M.D.

Doctor Wadsworth was Councilor of the Second District Medical Society from 1931 to 1942, and had served as secretary of the Martin County Medical Society from 1914 to 1918, inclusive, and from 1921 to 1929, inclusive. He had been a member of the Committee on Secretaries' Conference in 1930 and 1931, the Committee on Study of High School Athletics from 1933 to 1943, inclusive, and the Committee on Pneumonia from 1939 to 1942, inclusive.

Doctor Wadsworth was a veteran of World War I, and was a member of the Daviess-Martin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Jacob Kaszer, M.D., of Plymouth, died at his home on May twenty-eighth, at the age of ninety-one years. Doctor Kaszer graduated from the University of Illinois College of Medicine, in Chicago, in 1886 and has had a career of more than sixty years of active practice in the medical profession.

* * *

Malcolm B. Fyfe, M.D., of Valparaiso, died on May tenth following a brief illness. He was seventy-one years of age. Doctor Fyfe graduated from the Northwestern University Medical School, in Chicago, in 1903 and had served in the United States Medical Corps during World War I. He was a member of the Porter County Medical Society, the Indiana State Medical Association, and the American Medical Association.



(Above) Fitting practice session at recent CAMP Instructional Course

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

May 25, 1947.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Floyd T. Romberger, M.D.; Cleon A. Nafe, M.D.; Walter L. Portteus, M.D.; Alfred Ellison, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: L. E. Burney, M.D., State Health Commissioner, and C. A. Stayton, M.D., chairman, Committee on Control of Cancer.

Membership Report

Number of members May 24, 1947	3,493*
Number of members May 24, 1946	3,339
Gain over last year	154

* Includes 106 in military service (gratis)
171 honorary members

Number of members December 31, 1946	3,509

Treasurer's Office

The treasurer reported that $5,000 from the general fund had been invested in Series G bonds.

1947 Annual Session, French Lick, October 28, 29, 30, 1947

Scientific program.

a. Program complete with exception of one speaker.

b. On motion of Doctors Nafe and Ellison, Dr. W. U. Kennedy, president of Mutual Medical Insurance, Inc., will be allowed fifteen minutes on the Wednesday morning program.

Annual dinner.

a. It was taken by consent that the president-elect of the American Medical Association would be invited to be the principal speaker at the annual dinner. The president of the A. M. A. was designated as the alternate.

b. On motion of Doctors Nafe and Romberger, $300.00 was allowed to cover the expense of procuring a second speaker for this time.

President's dinner. On motion of Drs. Romberger and Nafe, decision on the question of holding a president's dinner on Wednesday night, October 29, was postponed until the next meeting of the Executive Committee.

Badges. The committee decided that a ribbon type badge should be used and it should be large enough to carry the name in large type. Samples are to be submitted at the next meeting.

Honorary members. Procedure for presentation to House of Delegates of names of members entitled to honorary membership was approved by the committee on motion of Doctors Ellison and Nafe.

Statements of receipts and expenditures for April for the Association committees and THE JOURNAL were approved.

Legislative Matters—National

Hearing on S. 545. The attorney was directed to give a digest of the new Wagner-Murray-Dingell bill (S. 1320) and the Taft bill (S. 545) at the next meeting.

On motion of Doctors Nafe and Romberger the executive secretary was instructed to contact the Bureau of Legal Medicine and Legislation to learn the American Medical Association's attitude on the Taft bill and to relay that information to members of the committee.

Organization Matters

Complimentary JOURNAL *to retired councilor.* The committee decided against the policy of sending THE JOURNAL complimentarily to any member or past member of the association. It felt that the member's local society should see that he receives THE JOURNAL.

Woman's Auxiliary Bulletin. On request of the president of the Woman's Auxiliary to the Indiana State Medical Association the committee allowed $500.00 to help defray expenses of publishing an Auxiliary Bulletin. This was done on motion of Doctors Portteus and Romberger.

Group health and accident insurance. The president-elect of the association was authorized to collect data on how other state medical associations handle this type of insurance.

Recognition of physicians who have practiced fifty years. Letters received from the Illinois State Medical Society was read and the executive secretary was instructed to submit a sample lapel pin for consideration at the next meeting of the committee.

Complaint against hospital employing unlicensed radiologist. Letter received from an Indiana physician read and referred to the Indiana Roetgen Society.

Complaint against physicians doing illegal operations. Letter received from the secretary of a county medical society stating that two physicians in his county are doing "a large number of cesarean sections on normal cases with the idea of sectioning the tubes." On motion of Doctors Nafe and Romberger, the executive secretary was directed to write the county society secretary that this is a matter for local censure. The attorney of the association is to send the secretary the legal powers of the medical staff of the hospital in regulating this practice.



the art of eating

Too many people "seem to feel that the art of eating consists of filling the stomach to capacity three times a day."[1] They ignore the fact that "calories alone do not make a balanced diet."[1] They need, therefore, and will continue to need, support of vitamin supplements. To better reconcile the science of nutrition with the "art of eating," Upjohn provides a full range of potent, balanced vitamin preparations. In a variety of dosage forms, Upjohn vitamins help paint a better nutritional picture for all age groups by obviating deficiencies or providing for their treatment in the practice of medicine and surgery.

1 J. South Carolina M. Assn. 52:186 (July) 1946.

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FINE PHARMACEUTICALS SINCE 1886

UPJOHN VITAMINS

Patronize Your Advertisers

Complaint of radiologist on newspaper publicity. Complaint of Indianapolis radiologist was referred to the Indianapolis Medical Society on motion of Doctors Nafe and Portteus.

Letters from the president of the American Medical Association and the former president-elect of the A. M. A. were read.

Advertisements against socialized medicine. Consent for use of advertisements submitted by the National Sales Foundation of Dallas, Texas, was given on the condition that they be approved by the local county medical society in the office of publication.

On motion of Doctors Nafe and Ellison the committee approved the purchase of a cabinet in which to file membership receipts.

Moving first year of I. U. Medical School course to Indianapolis. On motion of Doctors Portteus and Romberger, the attorney of the association is to send excerpts from an article written by Dr. H. G. Weiskotten and published in the April 12, 1947, issue of The Journal of the American Medical Association to the members of the Board of Trustees of Indiana University, the president of the University, and the Governor, the purpose being to show that Indiana University is jeopardizing the rating of its medical school by continuing to give the first year of medicine at Bloomington.

Proposed Division of Cancer Control at State Board of Health. Doctor Burney explained that federal money is available to set up a Division of Cancer Control and asked whether this would meet with the approval of the association. Decision on this subject was postponed until the next meeting of the committee, and in the meantime the secretary was instructed to contact the Indiana Roentgen Society and the Indiana Association of Pathologists and obtain their view on the proposal. Doctor Burney was asked to find out whether other state health boards have cancer control divisions.

Question of using Indiana Cancer Society funds for treatment purposes. The chairman of the Committee on Cancer Control of the Indiana State Medical Association appeared before the Executive Committee and explained that the executive committee of the Indiana Cancer Society had denied the request of a county medical society for use of funds to treat indigent cancer patients and asked whether the committee supported this policy. On motion of Doctors Nafe and Portteus the Executive Committee approved the position taken by the executive committee of the Indiana Cancer Society and the Committee on Cancer Control of the Indiana State Medical Association, i. e., that no county projects in which funds of the Indiana Cancer Society would be used for the treatment of patients afflicted with malignant disease will be approved except in an emergency, the question of the emergency to be determined by the Service Committee of the Indiana Cancer Society.

On motion of Doctors Ellison and Portteus, the Executive Committee recommended that the Indiana Cancer Society employ a physician for the position of full-time executive vice-president.

Indiana Hospital and Health Center Program. Doctor Burney told of the progress made by the State Board of Health in the survey of hospital needs in Indiana, including the recommendations for new hospitals and additions. On motion of Doctors Nafe and Ellison, the hospital program was referred to the Committee on Medical Education and Hospitals for study and recommendation. This committee is to report to the Executive Committee at its next meeting.

State Board of Medical Registration and Examination and Cult Practice.

1947 annual registration. The secretary reported that the State Board of Medical Registration and Examination was sending notices to physicians sometime in June. It was suggested that the secretary procure a list of physicians who have not yet registered on August 1 and remind them to do so.

The Journal.

Report on advertising:

Additions	$471.09
Decreases	545.11
Total decrease in April and May	$ 74.02
Total decrease for year	$ 37.61

Insurance company advertising. It was moved by Doctors Nafe and Romberger that in the future copy of advertisements of insurance companies for use in THE JOURNAL shall be approved by the chairman of the Executive Committee and the attorney before it is accepted.

General Practice number. Upon decision of the Editorial Boad the September issue of THE JOURNAL will be the General Practice number.

There being no further business, the committee adjourned to meet again at 6:30 p. m. Saturday, July 19, 1947.

BUREAU OF PUBLICITY

May 9, 1947.

Present: H. G. Hamer, M.D., chairman; Ray E. Smith, executive secretary.

The following "Hints on Health" columns for weekly newspapers were approved:

Week of June 9, 1947—"Care of the Feet."
Week of June 16, 1947—"Adolescent Acne."
Week of June 23, 1947—"Danger in Self Aid."
Week of June 30, 1947—"Astigmatism."

Letter from W. W. Bauer, M.D., director, Bureau of Health Education, American Medical Association, in regard to radio transcriptions was read.

Suggested advertising program for Indiana State Medical Association, submitted by Scheerer & Co., Chicago, was noted.

A series of fifty-two advertisements prepared by the National Sales Foundation, Dallas, Texas, were



KAPSEALS®
50 mg. each,
in bottles of 100
and 1000.

BENADRYL® hydrochloride

The results of a recent survey of the clinical use of Benadryl (diphenhydramine hydrochloride) in 2665 patients are shown in the accompanying table.

The efficacy of this new antihistaminic is also attested to in over 150 reports published in the medical literature.



ELIXIR
10 mg. in each
teaspoonful, in pints
and gallons.



CAPSULES
25 mg. each,
in bottles of
100 and 1000.

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THERAPEUTIC RESULTS WITH BENADRYL IN 2665 PATIENTS

Clinical Entity	Patients	Satisfactory	Questionable	No Benefit	% Showing Improvement
URTICARIA	766	692	16	58	90.3
VASOMOTOR RHINITIS	349	268	2	79	76.7
ECZEMA	128	79	7	42	61.7
HAY FEVER	425	350	36	39	82.4
ASTHMA	435	275	7	153	63.2
MIGRAINE	73	48	1	24	65.7
ANGIONEUROTIC EDEMA	54	46	1	7	85.2
ATOPIC DERMATITIS	66	42	1	23	63.6
PRURITUS	24	18		6	75.0
ERYTHEMA MULTIFORME	28	22		6	78.6
DERMOGRAPHIA	20	15		5	75.0
FOOD ALLERGY	37	32		5	86.5
CONTACT DERMATITIS	63	49		14	77.7
PHYSICAL ALLERGY	11	7		4	63.6
REACTIONS—ANTIBIOTIC	84	81	1	2	96.4
REACTIONS—DRUGS	46	42		4	91.3
REACTIONS—BIOLOGICS	12	12			100.0
DYSMENORRHEA*	44	38		6	86.3
TOTALS	2665	2116	72	478	79.39

*those cases due to histamine-induced spasm of smooth muscle.

Benadryl hydrochloride

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY, DETROIT 32, MICHIGAN

reviewed. It was the concensus that they were excellent advertisements, very well written and attractively designed, but the question of writing a letter of approval on behalf of the Indiana State Medical Association was referred to the Executive Committee of the association.

The secretary of the bureau reported that speakers had been procured for the following meetings:

May 21, 1947—Decatur County Medical Society, Greensburg.

May 22, 1947—Southwest Regional Conference, Indiana State Conference on Social Work, Evansville.

May 22, 1947—First District Medical Society, Princeton.

June 5, 1947—Indiana State Federation of Clubs annual session, Indianapolis.

LOCAL SOCIETY REPORTS

Clinton County Medical Society members held a dinner meeting on May sixth at the Clinton County Hospital, in Frankfort. Case reports were given by Dr. Milton W. Erdel, of Frankfort, and Dr. John S. Ketchum, of Rossville, on the successful use of Vitamin B Complex in a rodent ulcer of the eye, and in a case of dry socket. Fifteen members attended the meeting.

The members met at Clinton County Hospital, in Frankfort, on June third, when fifteen members were present. Dr. Gerald Kempf, of Indianapolis, spoke on "Management of Communicable Diseases."

* * *

Elkhart County Medical Society members met on May first, at Hotel Elkhart, in Elkhart. The fifty-four members present heard Dr. Kenneth N. Campbell, of Ann Arbor, discuss "Current Trends in Vascular Disease."

* * *

Fayette-Franklin County Medical Society members met on May thirteenth at the McFarlan Hotel, in Connersville. Thirteen members attended the meeting which was addressed by Dr. Robert Goodsen, of Chicago, whose subject was "Cesarean Section and Caudal Anesthesia."

* * *

Floyd County Medical Society members held a dinner meeting in New Albany on May ninth. The eighteen members present heard Dr. Martin B. Strange, of New Albany, discuss "Office Diagnosis of Ruptured Nucleus Pulposus."

Greene County Medical Society members met at the Freeman Greene County Hospital, in Linton, on May fifteenth. The guest speaker was Dr. A. H. Fender, of Worthington, whose subject was "Endometriosis." Eleven members were in attendance.

* * *

Hendricks County Medical Society members held a dinner meeting at the Ulen Country Club, in Lebanon, on May sixth. Dr. Robert Wiseheart, of Lebanon, spoke on "World War II Experiences Inside Russia." Seven members, their wives and guests attended the meeting.

* * *

Johnson County Medical Society members held a meeting on May twenty-eighth, at the Johnson County Memorial Hospital, in Franklin. Nineteen members attended the meeting.

* * *

Noble County Medical Society members held a luncheon meeting at the Kendallville Country Club on May first. Eight members attended the meeting.

* * *

Parke-Vermillion County Society members held a dinner meeting on May twenty-first, at the Vermillion County Hospital, in Clinton. Dr. Robert R. Brown, of Terre Haute, presented a paper on "Treatment of Urinary Tract Infections." The meeting was attended by eleven members.

COUNCILOR DISTRICT MEETINGS

First District Meeting

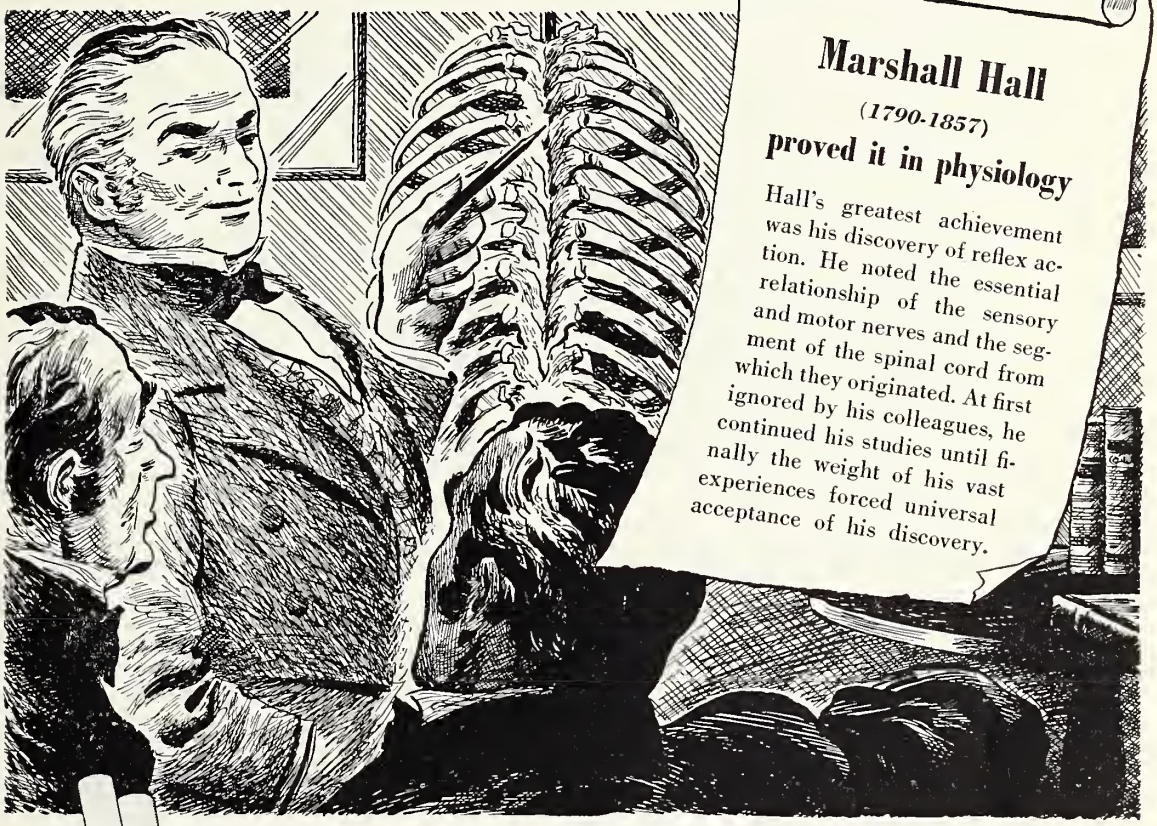
Meeting at the Princeton Country Club near Princeton, on May twenty-second, the First District Medical Society elected the following officers for 1948: Dr. George W. Willison of Evansville, president; Dr. Virgil McCarty of Princeton, vice-president; Dr. Williard T. Barnhart of Evansville, secretary-treasurer; and Dr. Herman Combs of Evansville, councilor. The 1948 meeting will be at Evansville.

Speakers at the dinner were: Dr. Cleon A. Nafe of Indianapolis, president-elect of the Indiana State Medical Association; Dr. I. C. Barclay of Evansville, councilor; and Ray E. Smith of Indianapolis, executive secretary of the state association.

Golf prizes were awarded to Dr. Isidor J. Raphael, of Evansville, and Dr. Wendell C. Stover, of Boonville.

Four members of the faculty of the Indiana University School of Medicine provided the scientific program in the afternoon as follows: "Poliomyelitis," by Dr. Lyman T. Meiks; "Treatment of Suppurative Lesion of the Chest," by Dr. J. Stanley Battersby; "Myasthenia Gravis," by Dr. Joseph E. Tether; and "Common Lesions of the Cervix," by Dr. Carl P. Huber.

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Second District Meeting

The Second District Medical Association was entertained by the Greene County Medical Society Thursday, June 12, at the Linton Country Club. The program included a business session; color films, "External Fixation Treatment Fracture of the Hip," and "Nephrectomy," by Dr. I. H. Scott, of Sullivan; "Diagnosis of Diseases of the Blood," by Dr. Paul J. Fouts, of Indianapolis; "Treatment of Symptoms of Menopause," by Dr. Sprague Gardiner, of Indianapolis. This program proved to be unusually interesting.

Officers elected for the coming year were: Dr. W. C. Reed, Bloomington, president; Dr. J. S. Brown, Carlisle, secretary. Dr. James Harvey Crowder, of Sullivan, was elected councilor for a three-year term. The place of the next meeting will be Monroe County.

Third District Meeting

Dr. Keith Hammond, of Paoli, was elected president of the Third District Medical Society at a meeting held at Silvercrest Sanitarium, near New Albany, May twenty-eighth. Dr. B. E. Sugarman, of French Lick, was elected secretary-treasurer.

French Lick was selected for the 1948 meeting place. The date will be decided later.

The physicians were welcomed by Dr. Parvin M. Davis, president of the Floyd County Medical Society, and Dr. Jerome V. Pace, superintendent of the sanitarium.

Dr. K. Armand Fisher, of Louisville, Kentucky, gave a scientific treatise on "Low Back Pain." Other speakers were Dr. A. P. Hauss, of New Albany, councilor; Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association; and Ray E. Smith, of Indianapolis, executive secretary of the association.

The district voted to invite the state medical association to sponsor a post-graduate course at New Albany.

Dr. Percy R. Pierson, of New Albany, president of the district society, presided.

Fourth District Meeting

Dr. George S. Row, of Osgood, was elected president of the Fourth District Medical Society at the annual meeting held in Seymour May fourteenth. Other officers elected were: Drs. Charles N. Manley, of Rising Sun, vice-president; Lloyd W. Hisrich, of Batesville, secretary; and Oscar A. Turner, of Madison, councilor.

Batesville was selected as the place for the 1948 meeting. The date will set by the Ripley County Medical Society.

Speakers on the scientific program were: Drs. George S. Bond and Gerald W. Gustafson, both of Indianapolis, and Maynard Murray, of Cincinnati. Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, and Ray E. Smith, executive secretary, were the banquet speakers.

The doctors' wives were guests at luncheon at the home of Dr. and Mrs. L. H. Osterman and, after a tour of Jackson County Park, were tea guests at the home of Dr. and Mrs. Garland R. Gillespie, of Brownstown.

Golf prizes were won by Dr. Harold L. Beddoe, of Madison, and Dr. D. W. Matthews, of North Vernon.

Ninth District Medical Society

The Ninth District Medical Society meeting held at Mudlavia Springs Hotel, near Attica, on May 15, was largely attended. In the morning golf was enjoyed by the doctors and their wives. After a buffet luncheon the ladies played card games and visited Mrs. Stanfield's Antique Shop while the doctors attended a scientific session.

The physicians were welcomed by Dr. Lee J. Maris, of Attica, president of the district society, and guests were introduced by Dr. Lowell R. Stephens, of Covington. The essayists were Dr. Lowell T. Coggeshall, chairman of the Department of Medicine, The School of Medicine, University of Chicago, "Current Status of Influenzal Vaccines"; Dr. Stuart R. Combs, of Terre Haute, "The Cardiac as a Surgical Risk," and Dr. Frank W. Peyton, of Lafayette, "Sterility."

Dr. Wemple Dodds, of Crawfordsville, councilor of the district, gave a report. Dr. Claude D. Holmes, of Frankfort, introduced a resolution passed by the Clinton County Medical Society which was for removal of control of the American College of Surgeons over hospital staff memberships. The district went on record as favoring the sentiments expressed in the resolution.

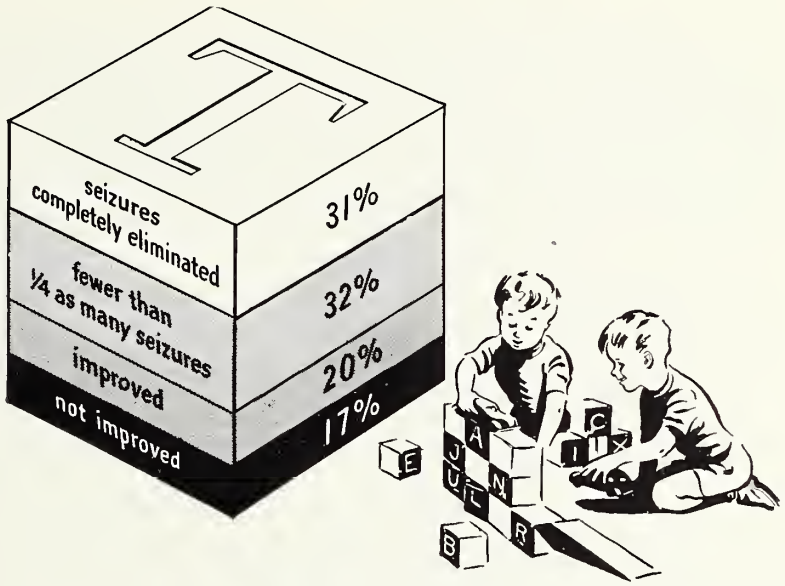
Speakers at the banquet were Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, and Ray E. Smith, of Indianapolis, executive secretary. Golf prizes were awarded to Drs. B. A. Burkhardt, of Tipton; R. B. Dubois, J. E. Engeler and Frederick A. Loop, all of Lafayette; William Mounts and Byron N. Lingeman, both of Crawfordsville; and John R. Porter, of Lebanon.

The 1948 meeting will be held in Fowler or Frankfort. The officers of the host county society will serve as the 1948 district officers. The date will be decided later.

Eleventh District Meeting

Dr. Stephen D. Malouf, of Peru, was elected president and Dr. O. G. Brubaker, of North Manchester, was re-elected secretary-treasurer of the Eleventh Councilor District Medical Society at the seventy-seventh semi-annual meeting held at Huntington May twenty-first. Doctor Brubaker has served twenty years as secretary-treasurer of the association.

Wabash county was selected as the place for the next meeting on September 17, 1947.



85% of petit mal cases improve with Tridione

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The afternoon session included reports by Dr. C. S. Black, of Warren, councilor, and other officers; an address by Dr. Max R. Adams, of Flora, president; a talk by Ray E. Smith, executive secretary of the Indiana State Medical Association; and two scientific lectures, "Peripheral Circulation: Its Derangements and Their Treatment," by Dr. Willis D. Gatch, of Indianapolis, and "Diagnosis of Diseases of the Blood: Laboratory Aids," by Dr. Paul J. Fouts, of Indianapolis.

Speakers at the dinner were: Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, and E. C. Gorrell, of Winamac, weekly newspaper editor, whose subject was "Homespun Philosophy."

WOMAN'S AUXILIARY to the Indiana State Medical Association

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OUR GOAL

"Every Physician's Wife an Auxiliary Member"

President's letter to Hoosier Doctors' wives:

After taking office as president of the Woman's Auxiliary to the Indiana State Medical Association on April 23, at the House of Delegates in Indianapolis, we drove back to Evansville. About the time we reached Spencer it suddenly came over me, "Becky, you've really got yourself a job this time. What are you going to do with it?"

Two phases of auxiliary work we want to stress this year, ORGANIZATION and PUBLIC RELATIONS. The problem is how to do this most effectively, how best to reach those physicians' wives who are not now members of an auxiliary and make them realize that we need them and they need us. The Indiana State Medical Association helped solve the problem on May 25 by allowing us enough money to publish a modest bulletin. We shall purposely start this bulletin small, hoping more that we can say that you will like it, use it, write us, and, above all, want it to grow larger.

With our membership now at 1,300 we have set a goal of 2,000 members for 1947-48. We hope to organize not less than 15 county auxiliaries this year. We have already made a start and have our first "baby." Perry County Medical Auxiliary was organized on May 26 with eight enthusiastic members. Mrs. P. J. Coultas, who has been a member-at-large for several years, was elected president. If you are interested in the medical auxiliary and have no county organization at present, become a member-at-large of the state auxiliary by sending $1.00 to Mrs. W. R. Morrison, 413 Conradt, Kokomo. From little acorns big oaks grow.

Public Relations to us is not so much a project as the sum total of all our contacts with the public. The effectiveness of any public relations program depends on whether our individual members are in the right place at the right time with the right information. Through the bulletin we hope to go a long way toward accomplishing this. The Indiana State Medical Association realizes that we will need the best possible advice, and at the May 25 meeting appointed their executive committee our Advisory Committee.

The year is only beginning. If every one of you will help a little we can and will make this the biggest year for any state auxiliary anywhere in the country.

WATCH FOR THE BULLETIN!

Rebecca Ratcliffe, President.

Medical Auxiliary Organized in County

A Medical Auxiliary was organized to the Perry County Medical Society on Monday evening at the home of Mrs. David A. Dukes, Tell City. Mrs. A. W. Ratcliffe, of Evansville, newly-elected state president, and Mrs. C. O. Richey, of Evansville, State Hygeia Chairman, were present and assisted with the organization plans. Mrs. Porter J. Coultas was elected president of the auxiliary, Mrs. N. A. James, vice-president, and Mrs. David A. Dukes, secretary and treasurer. Meetings will be held monthly on the last Tuesday of each month. A committee of three was appointed to formulate a constitution. Among the aims and purposes of the auxiliary will be to extend the aims of the medical profession to all organizations which look to the advancement of health and health education.

Books

RECEIVED

OBSTETRICAL PRACTICE: By Alfred C. Beck, M.D., Professor of Obstetrics and Gynecology, Long Island College of Medicine; Obstetrician and Gynecologist-in-chief, Long Island College Hospital, Brooklyn. 966 pages with more than one thousand illustrations. Price, $7.00. Cloth. The Williams & Wilkins Company, Baltimore, 1947.

THE UNCONQUERED PLAGUE. (A Popular Story of Gonorrhea.) By Harry Wain, M.D., Fellow of the American Public Health Association, Fellow of the American Medical Association, Troy, Ohio. 119 pages. Price, $1.50. Paper. International Universities Press, New York, 1947.

EXPERIENCES WITH FOLIC ACID. By Tom D. Spies, M.D., Associate Professor of Medicine, University of Cincinnati School of Medicine, Director of the Nutrition Clinic, Hillman Hospital, Birmingham, Alabama. 110 pages. Price $3.75. Cloth. The Year Book Publishers, Inc., Chicago, 1947.

FUNDAMENTALS OF CLINICAL NEUROLOGY. By H. Houston Merritt, M.D., Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University; Chief of Division of Neuropsychiatry, The Montefiore Hospital; Fred A. Mettler, M.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University; Tracy J. Putnam, M.D., Professor of Neurology and Neurological Surgery, College of Physicians and Surgeons, Columbia University. 289 pages. Price $6.00. Cloth. The Blakiston Company, Philadelphia, 1947.



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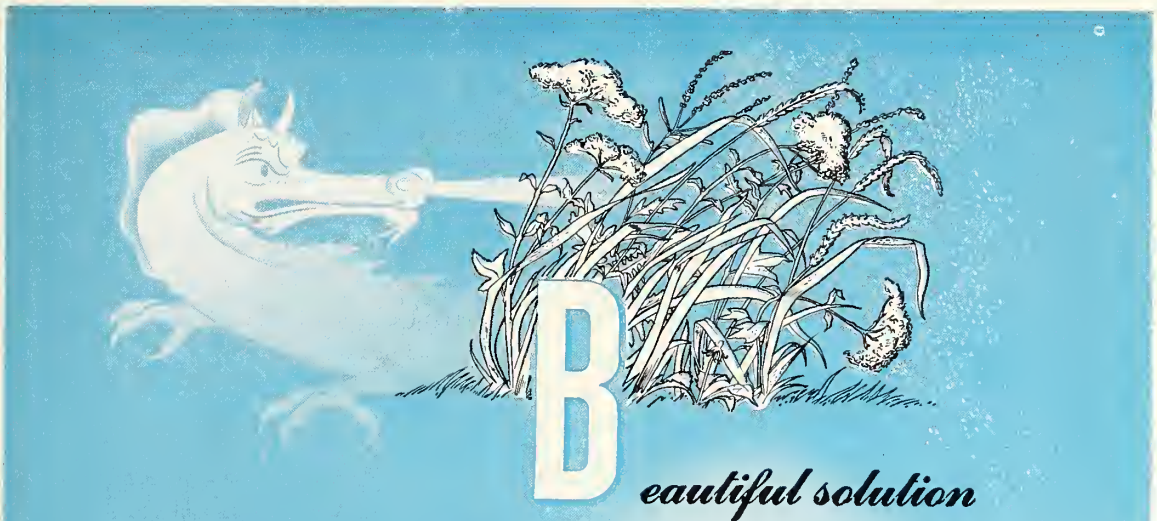


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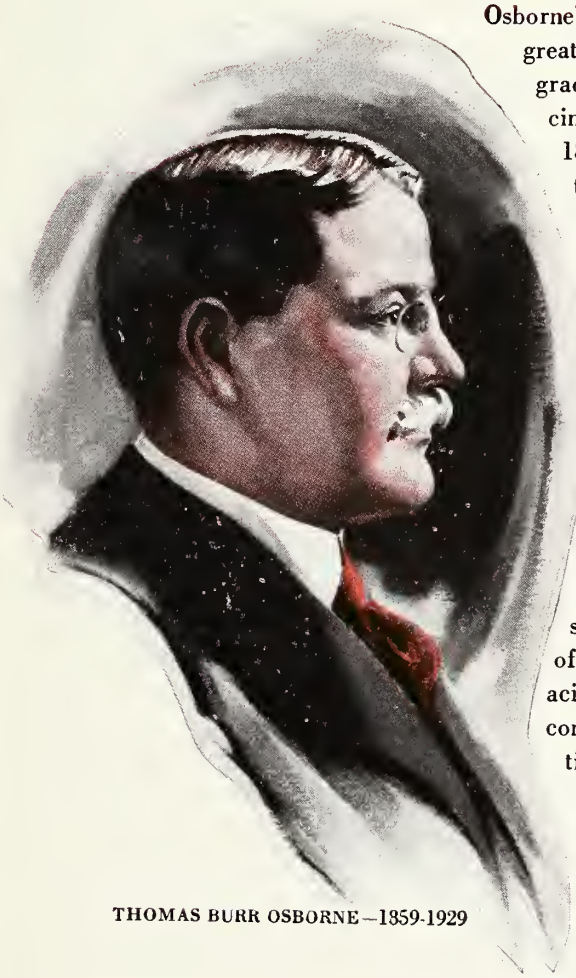
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Men and Amino Acids



THOMAS BURR OSBORNE—1859-1929

Osborne's forty years of research effort contributed a great deal to our modern knowledge of proteins. On graduating from Yale University, he studied medicine for a year, then took a Ph.D. in chemistry; in 1886 he began his lifework as a staff member at the Connecticut Agricultural Experiment Station under Professor S. W. Johnson. His work on vegetable proteins was presented in an important series of papers dealing with the proteins of no less than 32 edible and other seeds. He revealed the inadequacy of characterizing protein preparations solely on the basis of their elemental composition; indicated that most of the known proteins could be classified by methods of amino acid analysis and by their physical properties; demonstrated that different types of plant and animal cells have distinctive protein patterns. With Mendel, he showed that the wide variations in nutritive value of different proteins were related to their amino acid content, and introduced the protein efficiency concept, about which much work in protein nutrition is now centered. With H. Gideon Wells, he investigated anaphylactogenic effects of vegetable proteins. The American Association of Cereal Chemists founded the Thomas Burr Osborne gold medal in recognition of his valuable work in cereal chemistry. He ranks, with Fischer and Kossel, among the greatest pioneers of protein research.

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TREATMENT OF ALLERGIC SYMPTOMS WITH A NEW ANTIHISTAMINE DRUG*

J. D. PEIRCE, M.D.

M. H. MOTHERSILL, M.D.

INDIANAPOLIS

INVESTIGATIONS made in recent years suggest that many symptoms of anaphylaxis and allergy are due to antigen-antibody interactions which liberate (or possibly activate) histamine or a histamine-like substance in the shock tissues. It is thought that other substances are also liberated but that histamine is the most important cause of the symptoms.

In 1910, Dale and Laidlaw[1] injected histamine into experimental animals and noted similarities between the resulting symptoms and those of anaphylactic shock. Best *et al.*[2] showed that histamine, or perhaps an inactive precursor of it, was present in the body tissues in considerable amounts. They speculated on the possibility of its release from the interior of the cells or its transformation from an inactive precursor to active histamine, and attempted to estimate what might happen if a large amount of the available histamine of the body were suddenly able to exert its intense physiological action. In 1936, Dragstedt and Mead[3] reported experiments indicating that many of the major symptoms of anaphylactic shock could be accounted for by the quantity of active histamine present in the blood and lymph at the time the reaction occurred.

These and numerous other observations led investigators to attempt to synthesize compounds which might in some way prevent or reduce the effects of histamine. Fourneau[4] gave his attention to phenolic ethers and amino alcohols as possible antidotes to histamine, and in 1933 reported on thymoxyethyldiethylamine which, for convenience, is frequently called "compound 929 F."[5] This product was too toxic for clinical use, but as time went on better drugs were described by Staub[6] in 1939, by Halpern[7] in 1942, by Bovet *et al.*[8] in 1944, and by Loew[9] and Mayer[10] in 1945. It has been shown by Friedlaender and others[11] that these drugs possess the ability to protect experimental

* From the Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis, Indiana.

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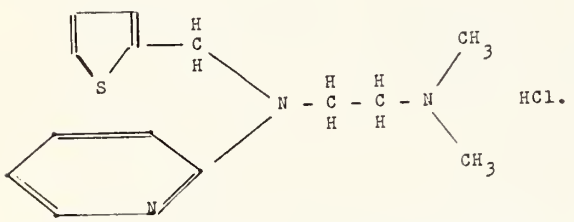
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animals against otherwise fatal doses of histamine, and that they can also protect sensitized animals against anaphylactic shock. The more recent of these compounds have demonstrated marked clinical effectiveness in alleviating allergic symptoms. Wells *et al.*[12] thought that the mode of action was of the nature of a competition between histamine and the antihistamine drug for a site of action.

Our purpose at this time is to give a preliminary report of clinical experiences with a new antihistamine drug. Chemically, it is described as N,N-dimethyl-N'(2-thenyl)-N'-(2-pyridyl)-ethylenediamine. For convenience it is frequently designated as "antihistamine drug 01013." Its graphic formula is shown in the accompanying figure.



Graphic formula of N,N-dimethyl-N'(2-thenyl)-N'-(2-pyridyl)-ethylenediamine

A limited supply of this compound was put at our disposal. On the basis of reports from Dr. Chen's laboratory,[13] it seemed probable that doses of 25 mg. were quite safe in the average adult and that larger doses could be given without danger. It was therefore decided to administer it first in doses of 25 mg. and later in amounts of 50 mg. or more if results seemed to warrant. The drug has been used in the treatment of various conditions including: (1) hay fever, (2) drug, food, and serum allergies, (3) transfusion reactions, (4) urticaria and other dermatitides, and (5) asthma. This report is preliminary. It is hoped that later a considerably larger number of clinical experiences with the drug will be given by other observers.

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CLINICAL EXPERIENCES

The accompanying table lists 77 cases that were treated with the drug. They are divided into five groups: (A) Hay Fever, (B) Bronchial Asthma, (C) Drug and Serum Reactions, (D) Skin Reactions due to causes other than drug or serum sensitivity, (E) Headaches. Undoubtedly these cases were not all due to allergy. The pruritus resulting from obstructive jaundice is not considered to be an allergic reaction, but two cases were available and were included with the idea of testing the possible effect of antihistamine therapy in this type of pruritus. Not all of the headaches that were treated can be considered as being due to the presence of histamine. The moderate relief reported in two functional headaches may have been coincidental or the result of suggestion. It is our belief that 62 of the 77 cases were evidences of allergic reaction, and that 9 of the remaining 15 may have had an allergic factor.

A. HAY FEVER

Twenty-one ragweed hay fever cases are reported. Three of these were treated at first on a total daily dose of 50 mg. with only moderate relief. Later they were given 100 mg. daily with complete relief in each instance. These three are therefore listed twice in the table. None of the untoward symptoms noted in the table were severe and they did not persist. One of the patients, for example, on the first day had unpleasant symptoms which she attributed to the drug, but she continued the treatment and the untoward symptoms did not reappear. The following protocol was supplied by one of the ragweed-sensitive patients whose symptoms included watery discharge from the eyes and nose, discomfort in the throat, and some coughing.

Variations in results obtained from the same dose of the drug in different individuals may be confusing unless one remembers the many variables which are involved. They include: (1) varying degrees of hypersensitivity, (2) degree of hyposensitization which may have been obtained by preseasonal treatment, (3) variations in pollen count on different days and at different hours of the same day, (4) possibility of symptoms caused by hypersensitivities to multiple allergens, (5) the presence of intercurrent infections or other illnesses which might in some instances simulate allergic symptoms and in other cases might mimic drug toxicity, and (6) the tendency of some patients to exaggerate allergic symptoms or untoward effects of the drug while others may unduly

Date	Dose	Time When Dose Was Administered	Time When Relief of Symptoms First Appeared	Time When Relief Ceased
Sept. 14	50 mg.	7:40 p. m.	7:55 p. m.	Midnight
Sept. 15	50 mg.	Midnight	12:15 a. m.	Sleep
Sept. 15	50 mg.	9:10 a. m.	9:25 a. m.	12:20 p. m.
Sept. 15	75 mg.	12:20 p. m.	12:30 p. m.	3:30 p. m.
Sept. 15	25 mg.	3:30 p. m.	3:45 p. m.	6:30 p. m.
Sept. 15	25 mg.	6:30 p. m.	6:45 p. m.	9:30 p. m.
Sept. 15	25 mg.	9:30 p. m.	9:45 p. m.	Sleep

minimize them. One cannot draw final conclusions on the results obtained in 21 ragweed hay fever cases, but it is of interest that the percentage of cases in which complete relief was obtained rose as the daily dose was increased from 50 mg. to 200 mg.

B. ASTHMA

It was not expected that the drug would be of much value in asthma, but it was used in five cases, all of which were severe. One patient who received a total of 400 mg. in less than one day complained of drowsiness, tinnitus, and anorexia with only moderate relief of the asthma. The other four patients on 200 mg. daily showed no improvement. The antihistamine drug did not appear to enhance the antiasthmatic action of ephedrine and epinephrine. The failure of orally administered antihistamine drugs to control symptoms of bronchial asthma is as yet unexplained.

C. DRUG AND SERUM REACTIONS

Of the 17 patients grouped under the classification of "Drug and Serum Reactions," there were 16 who displayed symptoms of allergy following administration of thiouracil, penicillin, streptomycin, or potassium thiocyanate. In each instance withdrawal of the allergenic drug was followed by a rapid disappearance of allergic symptoms, but since it was desirable in each case that the offending drug be continued for its therapeutic effect the antihistamine drug was also given. In 15 of these 16 cases the use of drug 01013 produced sufficient relief to permit use of the allergenic drug for indefinite periods. For example, a seven-year-old girl was able to take 1 Gm. of streptomycin daily for three months with the aid of 100 to 150 mg. of antihistamine drug 01013 per day. When the antihistamine drug was withdrawn and the streptomycin continued, urticaria and pruritus occurred. It may or may not be significant that during this prolonged use of streptomycin no symptoms involving the eighth nerve could be detected by weekly audiometer tests. Untoward symptoms attributable to the antihistamine drug were not manifested in this case in spite of the fact that treatment was prolonged. In the entire group of 17 patients there were only two instances of undesirable symptoms thought to be caused by drug 01013. Both patients continued the therapy and had no recurrence. One patient taking potassium thiocyanate experienced no relief from symptoms of drug allergy and therefore discontinued the therapy.

Tetanus antitoxin caused a very severe reaction in a sixteen-year-old girl. The pruritus was promptly and effectively relieved by this drug. However, certain pains in the region of the joints were only partially relieved on a dosage of 300 mg. per day.

D. OTHER SKIN REACTIONS

Certain skin reactions other than those due to drug or serum sensitivity were also treated. The pruritus of two cases of obstructive jaundice and three of four cases of neurodermatitis was not benefited. The three cases of neurodermatitis were subsequently relieved following the use of barbiturates. It seems probable that histamine was not a factor in the pruritus of these six cases but that it was a factor in the remaining sixteen. In these latter cases the use of antihistamine drug in doses of 50 to 200 mg. daily was followed by complete relief in nine and moderate in six. In two cases of urticaria due to known food allergy, the patients on several occasions deliberately ate the allergenic food and took the antihistamine drug *after* the urticaria had appeared. Relief from pruritus and headache followed in less than an hour, but the eruption required up to twenty-four hours or more to fade. However, it disappeared more rapidly than on other occasions when no drug had been taken. One of the subjects then took 50 mg. of the drug a half hour *before* eating the offending food and repeated the dose at four and twelve-hour intervals thereafter. On this treatment no rash appeared. This suggests an important prophylactic use for antihistamine drugs in cases where the allergen is known and exposure to it is controllable.

E. HEADACHE

Patients with headache included four with hypertensive headaches, three with histamine-induced cephalgia, and five that were diagnosed as functional. The three patients with histamine-induced headaches were completely relieved by a single dose of 100 mg. of the drug. The others were not helped. The five cases of functional headache demonstrated no special sensitivity to histamine and were not benefited by a course of "histamine desensitization."

TRANSFUSION REACTIONS

It has been believed for some time that histamine may be involved in the reactions following whole blood transfusions. Accordingly, a group of patients who required multiple transfusions were given doses of 50 to 100 mg. of the antihistamine drug before each transfusion and their reactions compared with a control group. The groups were made up of patients with anemia due to: (1) splenic panhematocytopenia, (2) leukemia, (3) aplastic bone marrow, and (4) chronic glomerulonephritis. The results were not conclusive. In the control group, eleven patients received 100 transfusions with 8.9 per cent reactions. In the treated group ten patients received sixty transfusions and had seven reactions (11.6 per cent). However, six of these seven reactions occurred in one patient. Further study of the cause of transfusion reactions is desirable.

RESULTS OF TREATMENT WITH ANTIHISTAMINE 01013 IN 77 PATIENTS EXHIBITING:

Condition	No. of Cases	Reaction	Other Therapy	Daily Dose 01013	Results			Untoward Symptoms from 0103 0103	Type
					C.R.*	M.R.*	N.R.*		
A. HAY FEVER									
Ragweed	1 (4)	Lacrimation **Rhinitis	1 had pre-seasonal desensi-tization	50 mg.	0	0(3)**	1	1	Headache
Ragweed	5	"	None	75 mg.	3	1	1	1	Dizziness
Ragweed	7	"	2 had desens.	100 mg.	5	1	1	1	Depression
Ragweed	6	"	None	150 mg.	5	1	0	1	Dizziness
Ragweed	2	"	None	200 mg.	2	0	0	1	Light-headedness
Totals	21 (24)				15	3(6)	3	5	
B. SEVERE BRONCHIAL ASTHMA									
Bronchial asthma	5	Dyspnea Orthopnea	None	200 to 400 mg.	0	1	4	4	Sleepiness Tinnitus Anorexia
C. DRUG AND SERUM REACTION									
Thiouracil sensitivity	3	Poly-arthritis	Thiouracil	150 to 200 mg.	2	1	0	0	
Penicillin sensitivity	6	General pruritus Urticaria	Penicillin	200 mg.	6	0	0	1	Sleepiness
Streptomycin sensitivity	4	Urticaria Pruritus	Strepto-mycin	150 to 200 mg.	3	1	0	1	Light-headedness
Potassium thiocyanate sensitivity	3	Dermatitis	Potassium thio-cyanate	200 mg.	0	2	1	0	
Serum reaction	1	Dermatitis	Tetanus antitoxin	300 mg.	1	0	0	0	
Totals	17				12	4	1	2	
D. SKIN REACTION (Other Than Due to Drug and Serum Therapy)									
Cold sensitivity	2	Urticaria	None	200 mg.	2	0	0	0	
Contact dermatitis	4	Dermatitis	None	50 to 200 mg.	3	1	0	2	Sleepiness Dizziness
Obstructive jaundice	2	Pruritus	None	200 mg.	0	0	2	0	
Neuro-dermatitis	4	Dermatitis	None	200 mg.	0	1	3	1	Light-headedness
Misc. urticaria. Unknown cause	4	Urticaria	None	200 mg.	1	3	0	2	Light-headedness Sleepiness
Misc. pruritus. Unknown cause	4	Pruritus	None	150 mg.	1	2	1	1	Sleepiness
Food allergy	2	Urticaria	None	50 to 100 mg.	2	0	0	0	
Totals	22				9	7	6	6	
E. HEADACHE									
Hypertension	4	Hyper-tensive headache	None	200 mg.	0	0	4	0	
Histamine induced	3	Cephalgia	Histamine	100 mg.	3	0	0	0	
Miscellaneous	5	Functional headache	None	100 to 200 mg.	0	2	3	0	
Totals	12				3	2	7	0	
Total for All Cases	77 (80)				39	17(20)	21	17	

* C.R.—Complete Relief.
M.R.—Moderate Relief.
N.R.—No Relief.

** 3 patients received only moderate relief on 50 mg. daily, later received complete relief on 100 mg.

TOXICITY

The accompanying table shows that seventeen of the seventy-seven patients complained of undesirable symptoms at some time during the course of treatment. Three of these reported more than one symptom. However, when it is realized that some of them took the drug for as long as three months, an isolated instance or two of lightheadedness or drowsiness during that time is not of great significance. The complaints usually occurred early in the course of therapy and did not as a rule recur. Rarely did these symptoms interfere with the patient's ability to continue the routine. In some cases, lowering the dosage obviated the difficulty without altering significantly the therapeutic effectiveness of the drug. Ordinarily 200 mg. could be taken daily with no discomfort.

The possibility of chronic or cumulative toxicity is of great importance, and since we had five patients who were treated for periods of three months with daily amounts of 100 to 200 mg. (av. 170 mg.) it seemed desirable to make a special study of them. Each of these five patients were investigated at the end of the three months in an effort to find evidence of damage to the blood, heart, liver and kidneys. Wherever possible, these findings were compared with similar tests made previous to the inauguration of antihistamine therapy. In no instance was any evidence of toxicity found. Either the findings at the end of the course were normal or they were no worse than before treatment was started.

The peripheral blood was investigated with reference to the hemoglobin, red and white cell count, the granulocytic series, and capillary fragility. Laboratory studies of the heart were made by teleoroentgenograms and electrocardiographs. Liver function tests included determination of the plasma protein with the albumin-globulin ratio, the cephalin-cholesterol flocculation, and the urine urobilinogen. Kidney tests consisted of chemical and microscopic urinalysis, nonprotein nitrogen (or blood urea nitrogen), concentrating ability of the kidney, sediment count (Addis), urea clearance, and renal hemodynamics (inulin-diodrast clearance).

It is, of course, to be realized that the absence of toxic findings in these five patients does not necessarily mean that there will be no chronic or cumulative toxicity in others who may take similar doses in the future. A study of a larger group of patients is desirable.

SUMMARY

1. A new antihistamine drug is discussed. Chemically it is N,N-dimethyl-N'(2-thenyl)-N'-(2-pyridyl)-ethylenediamine.

2. Seventy-seven patients received this drug for periods varying from one day to three months and in doses ranging from 50 to 400 mg. daily.

3. The medication exhibited its greatest effectiveness in: (a) acute urticaria due to drug and food allergy, (b) lacrimation and rhinitis due to pollen sensitivity, and (c) histamine-induced headaches. Its oral use in bronchial asthma was discouraging. Results in blood transfusion reactions were inconclusive.

4. The effective dosage ranged from 50 to 400 mg. daily, the average maintenance dose for all cases being between 150 and 200 mg.

5. On doses of 200 mg. per day, subjective toxic symptoms were usually absent. If they appeared they frequently did not persist when the medication was continued.

6. Signs of objective toxicity were sought for and not found in five patients who took an average of 170 mg. daily for periods of three months each.

7. These observations suggest that this compound probably has high antihistamine effectiveness and relatively low toxicity.

CHRONIC HEART DISEASE AND HEART FAILURE*

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THIS paper is an attempt to understand and compare the mechanisms involved in the production of chronic heart disease and failure, with some consequent implications in treatment. The main conditions to be considered are hypertensive heart disease, chronic valvular disease following rheumatic fever, and chronic arteriosclerotic heart disease, exclusive of acute coronary episodes. Each of these diseases may exist for a considerable time without symptoms. The first objective sign to appear is slight enlargement of the heart, which may progress slowly and may ultimately end in failure. Such failure often appears rather suddenly and frequently without many preliminary symptoms.

In hypertensive heart disease, most observers agree that enlargement of the heart is due to an increase in work required of the heart incident to the high blood pressure.[1] This concept is entirely supported by findings at the autopsy table. When there has been significant strain on the heart over a considerable period, simple hypertrophy and dilatation is found, frequently with no other changes on gross or microscopic examination.[2]

The extra work of the heart in hypertension that leads to hypertrophy has been called extrinsic heart strain, or strain outside the heart.[3] If that is true, it should be possible to find other examples of extrinsic heart strain besides hypertension. Examples of this do occur, although, from a clinical standpoint, most of these are not seen very frequently. For instance, coarctation of the aorta, which is a congenital condition, causes cardiac hypertrophy. Patent ductus arteriosus, another congenital condition, is a form of extrinsic cardiac strain, which causes hypertrophy of the heart if the defect is sufficiently large. Arteriovenous aneurysms, particularly of the leg or arm, constitute an extrinsic strain that may lead, not only to enlargement, but also to failure. Pulmonary fibrosis acts as an extrinsic strain on the right side of the heart, with resulting hypertrophy. Hyperthyroidism frequently reaches the point where it produces significant extrinsic cardiac strain and cardiac enlargement.

Some of these conditions that have been given as illustrations of extrinsic cardiac strain are amenable to treatment. If such strain is the cause of enlargement, and the strain can be removed, then the heart should tend to return to normal size. That is precisely what happens. A most striking improvement occurs with arteriovenous aneurysms. Even after heart failure has occurred, removal of such a strain, by surgical treatment, enables the heart to regain its compensation and return to normal.[4] This improvement occurs in a relatively short time, indicating that no great anatomical change had occurred in the heart. Results of surgical treatment in this condition are spectacular.

The operation of tying a patent ductus arteriosus is being done frequently at the present time. One might expect that cardiac enlargement or embarrassment would be relieved when such an operation is successful. That is exactly what happens, and accurate measurements have shown that the heart can return to normal size.[5] A few patients with coarctation of the aorta have been operated successfully.[6] Undoubtedly, the correction of such a condition would abolish any cardiac enlargement. Of course, the fact that cardiac involvement in hyperthyroidism is relieved by successful removal of the thyroid is well recognized. Such hearts frequently return to normal.[7] And, finally, the results of the treatment of hypertension by surgery should be considered. Most of the observations following such treatment have been concerned with blood pressure readings, but enlargement of the heart tends to disappear when the treatment is successful.[8]

It can be concluded, then, that any kind of extrinsic heart strain can cause cardiac enlargement, further, that enlargement is proportional to the degree and duration of the strain. While hypertension is the most common cause of this strain,

* Presented before the Section on Medicine of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

[1] Fishberg, Arthur M.: *Heart Failure.* Philadelphia, Lea & Febiger, 1940, p. 360.

[2] White, Paul D.: *Heart Disease.* New York, MacMillan Co., 1944, p. 434.

[3] White, Paul D.: *Heart Disease.* New York, MacMillan Co., 1944, p. 583.

[4] White, Paul D.: *Heart Disease.* New York, MacMillan Co., 1944, p. 703.

[5] Bourne, Geoffrey: Ligature of Patent Ductus Arteriosus, *British Heart J.*, Vol. 7, No. 2, April, 1945, p. 91.

[6] Gross, R. E.: Surgical Correction for Coartation of the Aorta, *Surgery* 18: December, 1945, p. 673.

[7] Fishberg, Arthur M.: *Heart Failure.* Philadelphia, Lea & Febiger, 1940, p. 572.

[8] Peet, M. M.; Woods, W. W.; and Braden, Spencer: The Surgical Treatment of Hypertension. *J.A.M.A.*, 115: November 30, 1940, p. 1875.

other causes are equally damaging in their effects on the heart.

In regard to chronic rheumatic heart disease, enlargement of the heart is also due to heart strain, but this strain is said to be intrinsic, that is, inside the heart. Acute rheumatic fever involves the heart, as a whole, including the myocardium, as well as the valves. When recovery from this acute or subacute infection occurs, the myocardial damage is largely repaired with little residual change. The valves, however, are often partly destroyed. Scar tissue is laid down in these valves, resulting contracture takes place, and the valve is left defective. Such a valve produces a strain on the heart, the location of the strain depending on the valve involved. For instance, aortic insufficiency causes a strain on the left ventricle, while mitral stenosis produces strain on the left auricle and backwards on the right ventricle. Eventually, all chambers of the heart are usually involved, although in severe mitral stenosis some atrophy of the left ventricle may actually occur.

If the intrinsic strain in chronic rheumatic valvular heart disease is largely a mechanical one, then any valvular defect should produce similar effects. And that is the case in syphilitic aortic insufficiency, which produces a strain with resulting enlargement, primarily on the left ventricle. Arteriosclerotic involvement of the valves, especially calcareous aortic stenosis, produces similar effects.

Other examples of intrinsic heart strain might be expected. This is exemplified by several varieties of congenital heart disease in which the valves or the septa of the heart are involved. Among those that can be mentioned are sub-aortic stenosis, pulmonary stenosis, patent foramen ovale, ventricular septal defect, tetralogy of Fallot, and so on. All of these are associated with enlargement of the heart, the location and extent of that enlargement depending on the location and extent of the lesion.

So far, enlargement of the heart, due to extrinsic or intrinsic cardiac strain, and often with no pathologic change in the heart, other than dilatation and hypertrophy, has been considered. But there are instances where the heart enlarges and often eventually fails, in which there is no evidence of any abnormal heart strain, either extrinsic or intrinsic. Such is the case in pure arteriosclerotic heart disease. The writer had the privilege of observing one such patient over a number of years. This patient came in for yearly physical examinations. At first, all findings were normal, including electrocardiographic tracings. The first indication that something might be wrong was a slight enlargement of the heart and a lowering of the T waves in the electrocardiogram. As time went on, the heart progressively enlarged slowly, and the T waves became lower. In spite of observation and treatment even before symptoms appeared, the patient gradually went into congestive heart failure. At no time was there any hypertension or valvular disease. The explanation of this situation is to be found in the blood supply and nutrition of the individual muscle fibers. There is general agreement that the maintenance of efficient cardiac function is dependent on an adequate flow of blood through the coronary arteries.[9]

The one point in this situation that has not been sufficiently emphasized, in the writer's opinion, is the normal work that is required of the heart. A normal heart, in a normal individual, has a normal amount of work to do in propelling blood through the vascular system and maintaining a normal blood pressure. For the sake of discussion, this may be called normal cardiac strain. The amount of work in foot-pounds that a normal heart does in twenty-four hours is amazing. It is not surprising, therefore, that conditions might affect the heart muscle in such a way that it would fail, even though carrying its normal load. That is precisely what happens in pure arteriosclerotic heart disease. If that is the case, then it should be possible to find other examples of enlargement of the heart and also failure without an increase in the load on the heart.

There are several situations where the heart fails with a normal load. In severe anemia the heart frequently enlarges and may fail. Correction of the anemia results in return of the heart to a normal function. In vitamin deficiency, such as beriberi, numerous cases have been reported where the heart has enlarged and often has failed. The institution of adequate vitamin therapy corrects this condition, and the heart embarrassment is relieved. Another outstanding example is hypothyroidism and myxedema. Patients with severe myxedema develop cardiac enlargement and often die from cardiac failure. This occurs with normal heart strain and may be corrected, when not too far advanced, by the administration of thyroid. Instances of heart failure in these conditions are not uncommon. In fact, when one considers what may be called the normal work required of the heart (normal cardiac strain), and remembers that the heart beats over 100,000 times each twenty-four hours over a period of years, it is surprising that it does not fail more often even under a normal load.

Thus far, instances of pure heart disease have been considered for the most part, such as hypertensive heart disease and arteriosclerosis. But these conditions seldom occur alone. Most patients with hypertension have, or develop arteriosclerosis, and patients with rheumatic heart disease may have other conditions. The writer had one patient who had rheumatic fever early in life that left him with mitral disease. About middle life he developed hypertension and hypertensive heart disease. He died relatively young of a coronary occlusion. He had, then, rheumatic, hypertensive, arteriosclerotic heart disease. It is well-known that women stand

[9] Levy, Robert L.: *Diseases of the Coronary Arteries and Cardiac Pain*, New York, MacMillan Co., 1936, p. 291.

hypertension better than men. That is due to the fact that men are more prone to coronary arteriosclerosis, so that a man with hypertension almost invariably has coronary arteriosclerosis, as well, while this is usually not such a great factor in women. It is obvious that any patient with more than one type of heart disease has a poorer prognosis. Many patients with hyperthyroidism also have hypertension. Their response to thyroidectomy is not as good as those patients who have relatively pure thyroid disease. It is entirely probable that avitaminosis is a larger factor in heart disease than we realize. Even though it may not be present early in cardiac enlargement, and then failure, it may become a factor because of the patient's inability to eat. Of course, this applies to general nutrition and the protein factor, as well.

In all of these chronic conditions that have been discussed the first significant change in the heart is enlargement. This is usually a gradual process, occurs over a period of years, and is often compatible with normal activity for a long time. In fact, it has been stated that hypertension in the average patient can exist for ten years before there is any appreciable effect on the heart. Then the heart slowly begins to enlarge, and this progresses until at the end of another ten years, making a total of twenty years, failure occurs. All chronic heart diseases tend to progress until symptoms of decreased cardiac reserve appear and eventually failure sets in. The actual mechanism of failure, which often occurs in a relatively short period of time, has been the subject of much discussion. One of the earliest and one of the most significant objective findings in failure in hypertensive, chronic valvular, and chronic arteriosclerotic heart disease is an increase in venous pressure. Obviously, there is some stasis in the fluid content of the blood vascular system, and fluid tends to collect in the venous system. The blood volume has to be considered as a factor in failure, therefore, particularly from the standpoint of treatment.

While many factors in the actual mechanism of failure remain to be settled, there are several so-called precipitating conditions that often immediately precede the failure. These include an upper respiratory infection, overexertion, severe cough over a considerable period, pregnancy, anemia, tachycardia, emotional upsets, and mental strain. Obesity may be a contributing factor. Tachycardia, or change in rhythm of any form, such as the onset of auricular fibrillation, may be a factor in the onset of failure.[10] A consideration of these factors as a whole shows that they constitute an additional extra strain on a heart that is already working under difficulties. From a practical standpoint, the possibilities of these additional strains should be kept in mind while observing a patient with heart disease before actual failure has occurred.

[10] Harrison, Tinsley R.: *Failure of the Circulation.* Baltimore, Williams and Wilkins, 1939, p. 121.

Treatment

With these concepts in mind, treatment of chronic heart disease should be directed in two ways: first, an attempt to relieve or reduce the heart strain, and, second, to improve the blood supply and nutrition of the heart muscle.

As soon as it is realized that a strain exists measures should be taken to reduce the work of the heart. Unfortunately, the majority of persons with chronic heart disease are unaware of the condition until failure occurs, and failure is a late stage in the disease. The condition may be discovered, however, in a routine health examination, in an insurance examination, when the patient has consulted the doctor for some other condition and a general examination is made, or a chest film for any purpose indicates some cardiac enlargement. When such a discovery is made, even though there are no symptoms, treatment should be considered. It is understood, of course, that an accurate diagnosis is made and any condition amenable to treatment is corrected. After that, the first consideration is reduction in the patient's activities.

There are few set rules for the handling of a patient with early chronic heart disease. Each patient has to be individualized. In some, the condition is discovered very early, good cardiac reserve is still present, and little limitation of activity is necessary. Even so, the patient should be informed of his condition, in the writer's opinion, except in rare instances, and he should be advised to consult a physician at least once a year. There is little hesitancy in discussing chronic valvular disease with a patient frankly. There is more hesitancy in hypertension, but certainly when this is definitely established, the patient should be so informed, and at the same time reassured. Further advice depends on the judgment of the physician who evaluates the extent of the condition and then inquires into the patient's mode of life.

When chronic heart disease is well established, and before failure has occurred, there are some generalizations that can be made. Regularity in hours of work and sleep is advisable. Perhaps a shorter working day should be arranged. Rest after the noonday meal for one-half to one hour may be necessary, and at least eight hours in bed at night. Week-ends should be spent leisurely, and vacations taken as they appear to be indicated. Besides regulation of activities, other measures are of value. Excessive weight should be reduced by regulation of the diet. This may be very important. Any anemia and vitamin deficiency should be corrected. Sedatives should be used liberally, particularly for sleep. In the writer's experience, it is best to give a mild preparation, such as phenobarbital, ¼ to ½ grain, before each meal and at bedtime. Finally, at the first symptom of breathlessness, or when the heart is con-

siderably enlarged and failure is imminent, digitalis should be commenced. When there is a factor of insufficient coronary flow, coronary vasodilators, such as aminophylline, should be tried.

After failure has actually set in, the principles of treatment are quite well laid out. These consist of rest, usually in bed, and ordinarily with toilet privileges; a light, or soft, salt-poor diet, occasionally with the limitation of food to four glasses of milk daily (Karrell Diet); and the restriction of fluids to about 1500 cc. daily. Digitalis is given up to the point of digitalization, or simply continued if the patient is already taking this medication. Apparently, digitalis increases the efficiency of the heart, and, once begun, should be continued for the remainder of the patient's life, in most cases. Diuretics, especially intravenous mercurial ones, are of great value in reducing the blood volume. After improvement has occurred, this medication should be continued once every week or two weeks, often for a considerable time. Venesection may be necessary in acute failure to reduce quickly the blood volume. Occasionally, the mechanical removal of fluid is necessary. Sedation, either in the form of the opiates, or barbiturates, is usually necessary for sleep, especially in relatively acute failure. Oxygen is frequently used. After the patient recovers from a siege of failure, rather strict regulation of his activities usually is necessary, and medications, especially digitalis, should be continued for a long time.

Conclusions

Two major factors are responsible for the production of chronic heart disease, namely, heart strain and impaired nutrition of the heart muscle. The strain may be extrinsic, as in hypertensive heart disease, intrinsic, as in chronic valvular disease, or the normal strain, with impaired nutrition, as in arteriosclerotic heart disease. Most commonly there is a combination of these in some form of strain with arteriosclerosis. All forms of chronic heart disease tend to progress, often slowly, toward heart failure.

Treatment should be begun early, and before failure occurs. Such treatment should consist of an attempt to reduce the heart strain and to improve the nutrition of the heart muscle.

WARTIME ADVANCES IN ANESTHESIOLOGY*

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WAR is tragically wasteful of life, time, and money. However, in the fierce concentration on victory of the best minds of all nations important scientific discoveries are made, and medical progress results from the opportunities to test on a vast scale theories of therapy that otherwise would require years of patient observation. It is true, therefore, that most wars have been associated with a remarkable increase in medical knowledge, and an attempt will be made to enumerate some advances made in anesthesia as a result of the accumulated experience of the last five years.

Professional Status

The war has markedly advanced the professional status of the anesthetist. As a result of the fine example set by a small group of well-trained men who volunteered early, and due to the influence of the high type of consultant appointed for the various theaters, the anesthetist in the Army hospital was placed in a position that he enjoys in few civilian institutions.

In most general hospitals he was equal in importance, if not in grade, with the chiefs of such major sections as general or orthopedic surgery. He was the key man of the surgical service, for "in addition to his other duties" it was his responsibility to organize and train the operating room staff of anesthetists, surgical nurses, and technicians. He was responsible for the aseptic technic of the operating room and, through the central service department, of the whole hospital. He arranged the surgical schedule; in this phase alone the productivity of the surgical service was directly proportional to the efficiency of the anesthetist. He frequently acted as supply and procurement officer for the surgical service. He was in charge of blood transfusions, the procurement and bleeding of donors, and supervision of plasma and other intravenous therapy; this assignment alone was of critical importance on a busy service.

* Read before the Wayne-Union County Medical Society, at Richmond, November 14, 1946.

He supervised oxygen and other inhalation therapy. His training in regional anesthesia made him a valuable consultant for diagnostic and therapeutic nerve blocks. The treatment of such immediate postoperative complications as shock and atelectasis was his responsibility. In brief, he was the spark plug and trouble-shooter for the whole surgical service and, as most military hospitals were predominantly surgical, the anesthesia section could make or break the hospital.

In the field the anesthetists assigned to field hospitals made an amazing record in the handling of non-transportable casualties. Due to careful, skillful anesthesia and adequate shock therapy, these cases were treated with a mortality that, judging from all previous experience, was actually miraculous.

Early in 1942 the Surgeon General of the Army asked the American Board of Anesthesiology for the names of 883 well-qualified anesthetists, which number, it was estimated, would be necessary to supply the Army alone. At that time there were only 230 Diplomates of all ages and sexes, many of them essential for the educational programs of their hospitals or medical schools. The American Society of Anesthetists was then contacted; they could supply the names of slightly more than 900 active members, many disqualified by age, sex, or physical disability, and not all competent to provide the desired service. It was obvious that an active educational program must be instituted immediately if the Army was to have any kind of adequate anesthesia. Accordingly, courses of instruction of twelve weeks duration were set up in five civilian institutions where adequate facilities existed. Later, as departments under well-qualified men were established, this training was taken over almost entirely by Army general hospitals in this country and the various overseas theaters. As a result of this program 564 medical officers were trained in this country alone, and an additional large number in overseas installations. It was possible to teach only fundamentals in such a short time, but an attempt was made to stress methods and technics required for casualty anesthesia. Nitrous oxide and ether, pentothal, endotracheal and regional block technics, and resuscitation were emphasized.

The training afforded by the Army was obviously inadequate; no attempt was made to turn out finished anesthetists, but the brilliant record made by anesthesia groups in combat areas reflects the soundness of the foundation established, and the ability, enthusiasm, and resourcefulness of the individual officers. Many of these physicians had no previous experience in anesthesia; most of them, through this training, have developed a keen interest in the specialty, and if encouraged to continue their training by academic instruction or preceptorships will form the backbone of the profession in the future, and will go a long way toward relieving the scarcity of capable men that is hindering the advance of professional anesthesia.

The accumulated experience of the past five years, covering as it does hundreds of thousands of anesthesias, with many different agents, to patients in all stages of physical deterioration, has crystallized our thinking and destroyed a number of pet theories about different drugs and methods.

Nitrous Oxide

The inflammable gases, ethylene and cyclopropane, were neither supplied nor permitted in Army installations, and anesthetists freely predicted that without cyclopropane a good anesthesia service was impossible. Actually, its absence was scarcely noticed. It was learned, or re-learned, if we had forgotten in our enthusiasm for newer gases, that nitrous oxide is an agent that has a wide field of usefulness. It is superior to cyclopropane in many respects for it is non-explosive and produces no cardiac disturbances. Induction and recovery are more rapid and more pleasant. If supplemented with sodium pentothal or minimal amounts of ether an efficient anesthesia without hypoxia can be obtained that is applicable in many situations where cyclopropane might seem to be first choice.

The technic, combined with pentothal, is simple and practical. Sufficient 2½ per cent solution for the needs of the morning is prepared in a sterile bottle, and just enough is injected intravenously to produce light anesthesia. It is unusual to exceed 500 mg. An oral airway is introduced and the anesthesia continued with nitrous oxide and oxygen. Ample oxygen can be given and good relaxation is obtained. In most cases no additional pentothal is necessary; the basal dose is completely metabolized during the anesthetic period, and the recovery is comparable to that following nitrous oxide anesthesia.

If the operation is prolonged, if more muscular relaxation is desired, or if good anesthesia cannot be maintained without the development of symptoms of hypoxia, additional 2½ per cent pentothal solution is added during the anesthesia. For this purpose a home-made syringe holder has been improvised from the standard laboratory burette clamp, locked on a short steel rod, welded to a carpenter's small "C" clamp. This can be fastened on either an arm board or the operating table. Such a contrivance makes it easy for the anesthetist to add, unassisted, more pentothal solution as required. A simple pinch or screw clamp on the rubber tubing connecting the needle adapter with the syringe prevents venous backflow. Very small amounts of additional pentothal solution added at intervals will prolong the initial basal pentothal anesthesia almost indefinitely.

The prolonged, intermittent administration of pentothal solution in small doses often has the disadvantage of clotting of blood in the needle be-

tween injections. The administration will be interrupted while the clot is removed or the needle changed. This difficulty may be overcome by the addition to the distilled water in which the pentothal is dissolved of 2½ per cent sodium citrate solution. Five cubic centimeters of citrate solution is used for every 50 cc. of distilled water.

An alternative method is to use a continuous flow of physiological saline from a standard vacoliter unit or similar venoclysis apparatus. The rubber tubing from this apparatus may be pierced by the needle from the pentothal syringe, and pentothal added intermittently without danger of clots obstructing the needle. A "Y" connection, improvised from a stethescope, is an improvement that prolongs the life of the rubber intravenous tubing.

In certain situations, where an arm board would inconvenience the surgeon or interfere with maintenance of an aseptic field, the following technic is used: Two grams of 2½ per cent pentothal solution is prepared. Basal anesthesia is induced as has been described. This usually requires less than 500 mg. The remaining pentothal solution is injected into a standard 1,000 cc. vacoliter bottle of physiological saline through the needle which acts as the air inlet. The strength of this solution will be approximately 0.15 per cent, and about 17 cc. will be the equivalent of 1 cc. of the standard 2½ per cent solution. A needle is introduced into an ankle vein, and this weak pentothal solution is allowed to flow continuously through the usual intravenous setup. A rate of one drop a second will give the patient about 500 cc. (0.7 gm.) per hour, and in most cases this will be sufficient to maintain the original basal anesthesia. Occasionally it may be necessary to increase or decrease this rate slightly; it is seldom too slow.

The depth of anesthesia may be varied by adjustments in the concentration of either pentothal or nitrous oxide, or both. However, it seems preferable to maintain the pentothal at a minimum basal level and vary the nitrous oxide according to the patient's needs. Recovery is more prompt, there is less postanesthetic depression, and the occurrence of anesthetic complications and postanesthetic pulmonary sequelae is reduced.

Sodium Pentothal

At the outbreak of hostilities it seemed as if pentothal, on account of its convenience and portability, would be the ideal military anesthetic, and it was enthusiastically used for a wide variety of operations by many men who were not familiar with its limitations and dangers. The results were disastrous. At Pearl Harbor, where it was given freely to those shocked and burned, severe respiratory depression, frequently fatal, was common after minimal doses. The mortality was 1 in 450 (.22 per cent) which was six times higher than that of all other agents combined.

The situation became so alarming that the Surgeon General considered prohibiting its use, but after study of the fatalities the following observations were made: As pentothal depresses the response of the respiratory center to carbon dioxide, respiratory action is maintained by the hypoxic stimulus of the carotid sinus-aortic mechanism. Hypoxia caused by shock or respiratory obstruction therefore will produce a respiratory stimulation which, being interpreted as light anesthesia, may result in a fatal overdose being given. Hypoxia must be avoided by the administration of oxygen. Pentothal increases vagal reflexes which may lead to severe laryngo- or bronchospasm, or cardiac inhibition. These reflexes should always be depressed by adequate doses of atropine. As pentothal does not depress the carotid sinus-aortic reflexes, operative trauma in the neck may set up powerful respiratory and cardiac inhibition by stimulation of this mechanism. It should not be used, therefore, for operations in the neighborhood of the carotid sinus.

"Pentothal should be avoided when the operative position or procedure may interfere with the airway or make artificial respiration difficult as in operations in the face down position, in operations on maxillofacial injuries or other injuries involving the airways. In intracranial surgery, pentothal is not a wise choice because such operations are usually long and are associated with great blood loss. Moreover, anoxia due to unexpected respiratory depression produces immediate swelling of the brain and may make an intracranial procedure difficult or impossible. Patients with severe burns tolerate pentothal poorly." [1]

Pentothal should be limited to procedures which will not consume more than thirty minutes, in which good relaxation is not essential, and to patients in good condition. Proper atropinization, routine oxygen administration, and careful observation of the air-way, pulse, and blood pressure at all times are essential for safety.

As a result of these restrictions governing the use of pentothal, in the next year the mortality dropped to 1 in 5,500 (.018 per cent), and this in spite of the fact that its use had increased from 53 per cent to 62 per cent of cases in the forward hospitals, and from 28 per cent to 48 per cent in rear areas. This large scale demonstration of the scope and limitations of pentothal anesthesia is one of the most important contributions of the war to anesthesia.

The solution may be kept a week or ten days without deterioration, and a combination of pentothal and nitrous oxide retains most of the advantages and avoids most of the dangers of these agents when used alone. Its administration was

[1] "Pentothal Anesthesia": *Bull. U. S. Army Med. Dept.* May, 1944.

facilitated by many ingenious gadgets improvised by field anesthetists.

Ether

Inhalation anesthesia with ether was shown to be a safe, in fact, the preferable anesthetic for those in shock, provided ample oxygen was available and the anesthesia was not too deep or prolonged. This was usually accomplished most easily by adding ether to a light nitrous oxide-oxygen mixture. This technic made ether practical in the tropics where it traditionally was contraindicated. The ingenuity of field anesthetists in improvising closed inhalers when conventional apparatus was not available overcame most of the disadvantages associated with high environmental temperatures. Of course, no war was necessary to demonstrate the simplicity and practicability of open ether.

Local Anesthetic Agents

As a result of numerous reactions associated with the use of the more toxic agents a number of principles were established. Infiltration anesthesia was limited to ¼ per cent or ½ per cent procaine solution; for nerve block 1 per cent or 2 per cent solutions might be used, but the total dose was not to exceed 2.0 grams. Cocaine was to be used for topical anesthesia in nose and throat work only. The strength was not to exceed 20 per cent; the dose was limited to 0.1 gram. Butyn, in concentrations not to exceed 2 per cent, was limited to surface anesthesia in eye surgery. Pontocaine (2 per cent) was permitted for topical anesthesia, but no anesthetic was to be injected into the inflamed, traumatised, or obstructed urethra.

Procaine was recommended as the spinal anesthetic agent of choice in doses up to 150 mg. In instillations where an experienced anesthetist was available, pontocaine and metycaine might be used. Apparently even expert supervision was inadequate for safe spinal anesthesia with metycaine, and it was eventually prohibited in all hospitals.[2]

That these restrictions constitute an advance in anesthesia may be debatable; however, there can be no doubt that they did and will make local and regional procedures much safer.

Choice of Methods

Patients in military hospitals can be divided into two major groups: those undergoing reconstructive or other elective surgery in rear areas, and casualties. The first group are usually young men in good physical condition and the choice of methods or agents presents few problems. Intravenous, regional, and spinal (in that order) were the most popular technics; all were well-tolerated, though a number of observations were made on the high incidence of pulmonary complications following spinal anesthesia. Institutions that were acting as training centers used more inhalation anesthesia.

In the combat zone casualties were classified as transportable or non-transportable. Transportable casualties were ten times as common and included simple wounds, compound fractures, and other injuries to the extremities that could be splinted and evacuated by ambulance to the rear for surgery. These patients were not in severe shock and their injuries were essentially minor. Evacuation hospitals, where most of these cases were treated, had to handle a very large volume of surgery with a minimum of trained anesthetic supervision, and therefore over half of these cases were anesthetised with sodium pentothal; local and regional methods were used in an additional 30 per cent. Field blocks were found to be inadequate, in that complete debridement was not always possible, which resulted in an increase in subsequent infection. Specific regional blocks were preferable; brachial plexus blocks proved very practical. Pentothal established itself as an invaluable agent for these minor cases.

Non-transportable casualties comprised those severely shocked, with multiple injuries, or severe wounds of head, chest, or abdomen. They required superlative anesthetic management under difficult combat conditions close to the front lines. Inhalation anesthesia with nitrous oxide-ether was found to be the anesthesia of choice and was used in the majority of these cases. Pentothal and spinal were contraindicated on account of shock; for multiple injuries inhalation was found to be more practical than regional procedures, though for simple procedures block anesthesia was used and was the second commonest method employed. For major cranial, thoracic, and abdominal surgery an endotracheal technic was found to be very satisfactory.

Shock

The improved treatment of shock was one of the most brilliant accomplishments of military surgery. The provision and timely use of adequate amounts of human plasma, and later whole blood, was possible for the first time in history. Plasma and blood in the ratio of two to one were given

[2] "Local Anesthetic Agents": *War Dept. Tech. Bull. TB Med.*, 43, May 18, 1944.

rapidly until the circulatory depression was overcome. This, together with the use of oxygen and other supportive treatment, literally snatched back from the grave thousands who otherwise would have perished. In anesthetising patients recovering from shock, it was observed that a profound morphine effect ensued as the improved circulation mobilized the drug from the site where it had been injected.

Diagnostic and Therapeutic Nerve Blocks

The war gave a great impetus to the use of nerve blocking for diagnosis and therapy. Many wounds of the extremeties caused marked vasomotor disturbances which could be relieved by producing a vasodilatation by blocking the appropriate sympathetic trunk. That mysterious syndrome, the causalgic state, often could be alleviated by a sympathetic block with procaine or alcohol, or if sympathectomy was contemplated would afford an indication of the degree of relief to be expected. Many other obscure pains could be relieved by nerve block of either sympathetic or spinal nerves, or information obtained thereby to indicate the origin. Infiltration anesthesia proved a useful treatment for sprains and very helpful for the reduction and transport of simple fractures.

Continuous Caudal Analgesia

An interesting development during the war has been the application of caudal analgesia to obstetrics. Caudal block, needless to say, has been used for many years as a satisfactory regional anesthesia for numerous genito-urinary and rectal procedures. Its application to obstetrics was limited by the short period of analgesia, averaging about one hour with procaine. Following Lemmon's demonstration that spinal analgesia could be greatly prolonged by the repeated injection of the analgesic drug through a spinal needle which was left in place, a similar technic was applied to caudal block. Very satisfactory analgesia could be obtained in most cases for an adequate time, although most labors were prolonged and an increased incidence of forceps extractions was noted due to the loss of bearing-down stimuli. Most of the failures and complications could be laid to technical errors, which were rather apt to occur with the methods originally used. The original technic required the insertion of a flexible steel needle through the sacral hiatus which was left in place throughout the rest of the labor. Through this, into the sacral canal, procaine or metycaine was injected at forty- to sixty-minute intervals to obtain continuous analgesia. The average time was six and one-half hours, though over thirty hours analgesia has been produced.

As might be anticipated, breaking or dislodgement of the needle became a common complication, and in an effort to prevent this, a No. 5 ureteral cathether, passed through a No. 13 needle, has been employed. This modification is technically difficult and has not proved completely satisfactory. The most simple and practical technic for prolonged caudal analgesia seems to be repeated single blocks with an agent giving prolonged effect, such as one-fourth per cent tetracaine (pontocaine) with epinephrin. One block with this drug will produce two and one-half to three hours analgesia and it is seldom necessary to give more than two or three injections for the average labor.

An interesting drug has been added to the armamentarium of the anesthetist. This is curare, the arrow poison of the South American Indians. This drug, first described by Sir Walter Raleigh nearly 350 years ago, has now been standardized and purified for clinical use. It has the remarkable property of producing complete relaxation of the skeletal muscles by interrupting the nerve impulse at the myoneural junction. The first muscles affected are those of the head and neck, then the extremeties, trunk, and lastly the diaphragm. Recovery is in reverse order. Relaxation will come on in two or three minutes after intravenous injection, and lasts for thirty to forty minutes. The principal danger is in respiratory depression, which is usually proportional to the dose. In a small number of cases there will be complete respiratory arrest, requiring artificial respiration. Curare produces no anesthetic effect, but is particularly helpful as a supplement to local, pentothal, or nitrous oxide anesthesia, where good muscular relaxation is not obtained. It can be used with spinal anesthesia that is wearing off, or where muscular relaxation is poor. It enables us to get good relaxation with cyclopropane in its lighter stages and thus avoid the dangers of cardiac disturbance in the more profound planes. It relaxes laryngospasm, frequently an annoying complication. It has greatly simplified our technic in the more difficult cases.

Summary

Contributions made by the war to the advancement of anesthesia included:

1. The placement of the professional anesthetist in a key position in the military hospital organization.
2. An educational program that increased by 50 per cent the number of available anesthetists.
3. A revival in the use of nitrous oxide.
4. A demonstration that sodium pentothal is safe only when used for short, minor operations on patients in good condition.
5. Showing that inhalation anesthesia with ether or nitrous oxide-ether was the anesthesia of choice for those in shock.

6. Confirming procaine as the safest all-round local agent.
7. Pentothal proved to be the most practical anesthesia for transportable casualties, regional was second choice.
8. For non-transportable casualties inhalation anesthesia produced best results. Endotracheal methods in major cranial, thoracic, and abdominal operations were lifesaving.
9. Plasma and blood transfusions were responsible for saving many from death from shock.
10. Nerve blocking was emphasized as a valuable diagnostic and therapeutic procedure.
11. Prolonged regional anesthesia has been introduced for obstetrics.
12. Curare is a useful aid in obtaining better muscular relaxation during anesthesia.

PRACTICAL CONSIDERATIONS OF SMALL BOWEL OBSTRUCTIONS*

H. D. Tripp, M.D.

PLYMOUTH

So much has been written on this subject that it is utterly impossible to cover more than the most essential features in a paper of this length. Most of the literature has occurred in the surgical journals, and not in the journals coming before the general practitioner. It is for this reason that I have chosen the subject, for it is the general men who most often see these cases first.

Until recently textbooks of surgery and teachers of surgery dwelled upon elaborate classifications of obstruction rather than elucidating on the more practical considerations. As surgeons became more aware of the disturbed physiology, pathology, and etiology of obstruction, a better understanding of the subject has come about.

Except for academic reasons a simple classification will suffice to provide a working knowledge of the subject from a practical standpoint. Ileus can be briefly dismissed because, strictly speaking, ileus is a paralysis of the musculature of the bowel and need not be the result of any obstruction to the fecal stream.

True obstructions then are the result of either intrinsic or extrinsic pathology. Intrinsic obstructions are produced by neoplasms or foreign bodies. Extrinsic obstructions result from pathology outside the lumen of the bowel. Intramural pathology, as in inflammatory and neoplastic disease, may cause obstruction.

Symptomatology: Colicky pain is perhaps the most prominent symptom, and is quite characteristic. The patient complains of having stomach cramps. The pains are rhythmical and increase in intensity as the process advances. They begin at a low ebb and gradually reach a crescendo, as one listens with the stethoscope, and they likewise decrease in decrescendo.

Pains are the result of the hyperstaltic movements attempting to empty the occluded bowel. Vomiting usually accompanies a painful contraction. The vomiting usually succeeds the onset of pain and occurs early or late in direct proportion to the level of the obstruction, being earlier in obstructions in that segment of bowel most proximal to the stomach, and later in those most distal to the stomach. Vomiting may or may not be projectile but does remain forceful while the bowel retains its contractability. When this is lost the distention increases and audible peristalsis is absent, ileus is then present as well as obstruction. Odor of the vomitus does not necessarily offer a criterion of the level of obstruction and to wait for the occurrence of fecal odor is to allow valuable time to escape before instituting measures of therapy. A fecal odor may come from fluids in the presence of bowel necrosis.

Temperature and Pulse: Temperature elevations may not be present unless the obstruction is associated with peritonitis or abscess formation. Its presence should arouse suspicions as to cause, infection, dehydration, or bowel necrosis. Systemic toxemia arising from infections outside the peritoneal cavity may cause abdominal distention and fever, with toxic vomiting. Intracranial lesions may also produce pictures simulating intestinal obstruction but without the colicky pains. Pulse elevations are more constant than temperature elevations, and increase with the age of obstruction.

Shock: All patients can be expected to show evi-

* Presented before the Marshall County Medical Society, in Plymouth, on September 4, 1946.

dences of shock as the process advances. Continued vomiting, causing loss of electrolytes, results in lowered osmotic effect of the blood and loss of tissue fluids. Necrosis of bowel, with attending transudates into the peritoneal cavity, act to produce circulatory failure by way of their toxic effect. Marked drops in blood pressure may not be noticeable at first but treatment with transfusions of plasma and whole blood should be started early to prevent shock, if not present when the patient is first seen.

Irritability and Tetany: Loss of chlorides through excessive vomiting may lead to alkalosis. Nervous irritability and increased reflexes may be the first indication of the development of alkalosis. Tetanic contractions should be watched for. Their presence in the case of intestinal obstruction can be taken as evidence of alkalosis unless otherwise proved, and calls for further replacement of chlorides intravenously.

Defecation and Passage of Flatus: A patient with a high grade obstruction may defecate or pass flatus. The material comes from the bowel below the point of obstruction and was present at the time the obstruction occurred.

Diagnosis

Nothing is more valuable in the diagnosis of intestinal obstruction than radiographs of the abdomen without contrast media. Good films taken in several positions can be depended upon to reveal the presence of obstruction as early as one hour after onset. Oschner,[1] in 1933, showed conclusively by experimental work that this is true. It is normal to see gas collections in stomach and colon, but gas is so thoroughly mixed with liquid in the normal small bowel that gas shadows do not appear unless there is obstruction. One familiar with the pattern of the colon will discover gas shadows evidenced by characteristic shadows on the plain film so that gas shadows in the colon offer no confusion. Location of the obstruction can be predicted fairly well by the contour and arrangement of the coils or loops of bowel. A distended portion of ileum will show smooth walls without indentations as compared to the colon which has haustral markings. A distended portion of jejunum will have smooth walls but also have transverse markings which are identical with the normal folds of the jejunal mucosa, giving to the distended bowel the stepladder pattern frequently referred to. The colon may also show these transverse markings due to the plicae semilunares but there are also haustral markings which the small bowel does not have.

[1] Oschner, Alton: The Value of Roentgenograms in Simple and Strangulated Obstruction, an Experimental Study. *Surg. Gyn. & Ob.* 56: 719-727, (April) 1933.

So, given a patient with symptoms of intestinal obstruction and positive radiographic findings leaves little guesswork in the diagnosis of intestinal obstruction. Refinements consist of determining the etiology, which will be taken up under that heading.

Etiology and Pathology: Intrinsic obstructions comprise those instances where a pedicled neoplasm suddenly obstructs the lumen of the bowel. Foreign bodies for the most part consist of gallstones that perforate the bowel through an artificial cholecystoduodenostomy. Other foreign bodies consist of swallowed objects. Intramural lesions may consist of malignant or benign neoplastic disease or chronic inflammatory diseases arising from the bowel wall.

Extrinsic causes comprise all the inflammatory lesions possible to occur within the peritoneal cavity, neoplastic disease, either primary or secondary, chemical irritations, and mechanical factors which cause strangulation, or volvulus, or intussusception. Under infections and chemical irritants come the reactions of the peritoneum and attendant exudative manifestations. The primary insult of gastric contents suddenly emptied into the peritoneal cavity is an example of chemical irritants, and the succession of events that follow causes adhesive occlusions of the small bowel; likewise, perforation of an appendix or other avenues of escape of fecal material causes a sudden general reaction of the peritoneal cavity with early ileus from toxic absorption. This allows greater surfaces of bowel to contact and form cohesions and resultant occlusion after the primary insult. A collapsed bowel has less chance of being involved in the exudate than the bowel insulted by toxin from existing infection, because of less surface area, and because peristaltic movements keep bowel surfaces from remaining in close contact for any great length of time. Therefore an obstruction in the face of peritoneal irritation from infection or chemical insult can conceivably become worse or obstructions occur at other levels if the bowel is not deflated from the very first. In the pelvis consideration must be given to acute and chronic pelvic inflammatory disease as a cause of obstruction. Pedicled tumors may cause strangulation, also a long Meckel's diverticulum. A ruptured ovarian cyst may set up peritoneal exudation sufficient to cause obstruction. Blood in the peritoneal cavity will likewise produce obstruction. Other chemical irritants consist of pancreatic ferments in pancreatitis, and bile, not forgetting the possibility of the talcum powder granulomata arising after operations where talcum powder particles get into the peritoneal cavity.

Postoperative obstructions may arise as a result of denudation of the peritoneal surfaces from rough handling of tissues, sponges that are too hot,

sponges that have been left behind, and infections. Radiation should not be forgotten as a cause of intestinal obstruction.

Strangulations include those due to the various external hernial strangulations and the internal hernial strangulations. We are less likely to remember the internal possibilities of strangulation, such as rents in the mesenteries, paraduodenal fossae, and diaphragmatic hernias.

As surgical technique has improved through the teachings of Halstead and others we all have seen fewer postoperative obstructions. Careful handling of tissues, accurate hemostasis, avoidance of mass ligatures, and accurate covering of denuded surfaces have lessened the incidence of postoperative obstructions, not forgetting, of course, the less frequent use of drains. Much work has been done to show the irritating effects of catgut on tissues in the form of exudation and edema at the site of operation. The peritoneum reacts to catgut as does other tissues and exudates are certain to form more abundantly in the presence of catgut than in cotton. It may not always be physically possible to cover denuded surfaces with peritoneum and in this event a useful expedient is the free or pedicled omental graft for this purpose. The extra time required to cover raw surfaces is time well spent. Replacing the sigmoid into the pelvis following pelvic surgery serves as a covering for any uncovered areas at the operative site. Bringing the greater omentum down before closing the peritoneum aids in closure and also prevents bowel loops from coming into contact with the peritoneal suture line. Closure of the peritoneum so that mesothelium apposes mesothelium theroretically leaves less raw surface on the under surface of the suture line.

Ligated pedicles should not be left without covering with peritoneum. Long ends distal to ligatured pedicles should also be cut away as they will only slough and set up tissue reactions and exudates. Much controversy exists over the matter of inverting the appendiceal stump, the chief objection being that a potential abscess is produced. If one uses a "rope" to ligate the base of the appendix then this is true, but why is it necessary to use anything heavier than 000 or 0000 plain catgut for this purpose? Small size catgut within the lumen of the bowel, being exposed to moisture, cannot last long enough for an abscess to form. Inversion leaves a smooth surface of the cecum rather than a ligated stump which will necessarily bring about some local reaction in a region where the distal ileum is so vulnerable to obstruction.

The cause of morbidity and mortality has been variously described and has received a great deal of attention. Present day opinions center around a few fundamental precepts. Loss of fluids and electrolytes with dehydration and PH. changes of the plasma contribute to the picture. Distention of bowel by intraluminal pressure embarrasses the circulation to the bowel with resulting tissue necrosis. Many anaerobic organisms flourish in the human bowel and thrive most abundantly in the presence of necrotic tissue. With necrosis and antecedent strangulation a bloody transudate occurs in the peritoneal cavity. Necrotic areas of bowel give away and allow fecal material to escape. Increased intra-abdominal tension from bowel distention impedes the return of venous blood to the heart, embarrasses respiration with further anoxia, and allows further coherence of bowel surfaces. Ultimately the patient dies from circulatory failure and shock as a result of toxemia and acid-base imbalances.

Laufman[2] has shown experimentally that the transudate occurring in the presence of strangulation obstructions is very toxic, and that small amounts are required to kill animals into which it has been injected. He also showed that adrenal cortex extract was effective in combating the effects of this toxemia.

Such etiologic factors as peritonitis abscesses and neoplastic disease responsible for obstructions also influence the morbidity and mortality.

Treatment

Proper management of intestinal obstruction calls for all the ingenuity and skill that the surgeon can muster. A thorough knowledge of physiology and fluid and electrolyte balance are prerequisites to the logical comprehension of therapy. Correction of fluid and electrolyte loss is the first step in the treatment. The amount and types of fluid administered depend upon the amount lost. Chlorides and carbonates are lost during vomiting that ejects both gastric and intestinal contents.

Nash[3] states that regardless of the serum chloride and carbonate level the intestine keeps on secreting these ions. About 3,000 cc. of intestinal juices are secreted in 24 hours, about 1,000 cc. of pancreatic juice is secreted, and between 500-1,000 cc. of bile excreted in 24 hours, making a total of about 4,500 cc. of fluids which normally are reabsorbed, for the most part. Total loss of this amount of fluid can rapidly dehydrate a patient. Herrin[4] has shown that distention of the intestinal canal accelerates the rate of secretion of intestinal juices from 170 to 567 per cent. Theoretically all fluids lost by vomiting or from intestinal fistulae should be replaced, volume for volume, with in-

[2] Laufman, H., and Freed, S. C.: Strangulation Obstruction, Experimental Study. *Surg. Gyn. & Ob.* 77: 605-609, (Dec.) 1943.

[3] Nash, J.: *Surgical Physiology.* Charles Thomas, Pub., 1942. New York.

[4] Herrin, R. C.: Chemical Changes in Intestinal Juice Produced by the Loss of Intestinal Juices. *J. Biol. Chem.* 108: (Feb.) 1935.

travenous normal saline. Young patients will tolerate from 4,000 to 5,000 cc. of intravenous fluids daily but the older patient cannot be expected to do so. His vascular system will not tolerate it, he may not tolerate large amounts of sodium chloride because of kidney damage, and he may develop pulmonary and cerebral edema, with resulting death. An easy method to determine when more saline is needed is to add a few drops of 5 per cent silver nitrate to a few cc. of urine. The appearance of a white precipitate indicates that sodium chloride is being excreted by the kidneys. No precipitate indicates that more saline is indicated. This test is based on the fact that the kidneys withhold sodium chloride when the serum chloride level is low. Nutritional requirements are met by administration of 5 or 10 per cent glucose in distilled water, and by adding to the solution vitamin B complex to aid in metabolism of the glucose. Adrenal cortical extract can also be added to the intravenous solution. On the basis of Laufman's work the addition of adrenal cortical extract would seem valuable, for the possibility of its value in fixing sodium in the tissues, which in turn influences the intercellular fluid exchange. Rhoades and associates,[5] however, concluded that in burn shock the substance was of no value in maintaining plasma levels, but that it does play a part in preventing other types of shock is well established clinically. Plasma and whole blood should be used depending on the plasma protein determinations.

Intubation and aspiration of the intestine was first advocated by Wangensteen, but it was found that the short intestinal tube does not adequately empty the small bowel. The original Miller-Abbott tube works well; however, considerable skill and patience is necessary to pass the tube. Often a stillette is needed and the guidance afforded by the fluoroscope. Harris[6] recently described a single lumen tube weighted with a mercury-containing bag which has proved to be a distinct advantage over the Miller-Abbott tube for aspiration. I have used this particular tube recently and find that it is superior, in that it passes almost by itself, and does a better job of emptying the intestine. Caution must be exercised in the use of the long tubes so that proper cases are selected for its use. Miller and Abbott originally designed their tube for use in the cases of obstruction due to adhesive occlusions. They believed that if such obstructions could be kept deflated for a certain period that resolution would take place and the obstruction would be relieved. In addition, pre- and postoperative use of the tube is indicated.

Nothing short of surgery will suffice to correct strangulation cases and certain cases due to exudative occlusions which do not resolve with deflation. The old adage that the sun should never set on a case of intestinal obstruction without surgical intervention was well taken at one time, but in present day methods the adage does not always hold. Especially is this true in cases seen late, who have gone past the point of being helped by surgery, yet even cases that might have been considered hopeless ones in former years may be gotten into condition by replacement of fluids and transfusions. Intubation lends much in bringing about a more rapid recovery. If resection should be necessary at operation the bowel that has been decompressed by intubation will lend itself to anastomosis better than the one which is edematous and distended; in the last event, anastomosis should not be attempted primarily, because of the great danger of leakage. A Mikulicz type of anastomosis should be provided for, with closure later, but in this event great care should be taken to correct fluid and electrolyte loss from the intestinal fistula. The lost intestinal fluid should be returned to the patient by proctoclysis. Large areas of bowel, plastered together, should not be dissected unless they contribute to the obstruction. In some events it may be better to short-circuit the bowel around the obstruction by side-to-side anastomosis. Raw surfaces of bowel, left after freeing adhesions, should be covered with a free omental graft to prevent another obstruction soon after surgery is instituted for the first obstruction. If intubation is not instituted after surgery, then a small catheter should be placed in the bowel by the Witzel technique, so as to serve as an escape for gas until the bowel regains its tone after surgery. This tube will not and cannot be expected to drain off much material, unless it is connected to a Wangensteen suction apparatus.

The use of prostigmine after surgery is indicated if resection has not been done. Its use keeps the coils of bowel collapsed and minimizes the danger of another obstruction shortly after relief of the first. Pitressin is indicated to keep the colon contracted, thereby allowing more room in the peritoneal cavity for the small bowel, and keeps the surfaces of the small bowel from contacting. The use of prostigmine alone to deflate the bowel is sometimes not too effective unless the large bowel is kept empty by the use of pitressin in conjunction. It must be remembered that prostigmine acts to contract the musculature of the small bowel, while pitressin acts on the musculature of the large bowel. Morphine in small doses keeps the bowel contracted while larger doses tend to allow for more dilatation.

[5] Rhoades, J. E.: Wolff, W. A.; Saltenstall, H.; and Lee, W. E.: Adrenal Cortex Extract in Burn Shock—Further Experiences. *Ann. Surg.* 118: 982-987, (Dec.) 1943.

[6] Harris, F. S.: Intestinal Intubation in Bowel Obstruction Technique, With a New Single Lumen Mercury Weighted Tube. *Surg., Gyn. & Ob.* 81: 671-678 (Dec.) 1945.

REVIEW OF TEN YEARS OF CESAREAN SECTIONS AT ELKHART GENERAL HOSPITAL

G. E. Bowdoin, M.D.

ELKHART

DURING 1936 to 1945, inclusive, there were 6,161 deliveries at Elkhart General Hospital. These were all private cases. A total of 163 sections were done, an incidence of 2.6 per cent. Nine general surgeons performed 155 of the sections.

Maternal Mortality.

There was one maternal death in the 163 sections, a percentage of .61 per cent.

Fetal Mortality.

There were twenty-one fetal deaths, a mortality of 11.5 per cent.

Morbidity.

The standard used was a temperature of 100.4 or over for two consecutive days or more, not including the day of operation. By this standard, there were twenty-five cases or 12.3 per cent showing morbidity. Morbidity was greater in those cases having labor, or ruptured membranes, or both.

TYPES OF OPERATION

Type of C. S.	Cases	Percentage	Morbid Cases	Percentage
1—Classical	155	95%	23	14.8%
2—Low flap	8	4.9%	2	33.3%

Type of Anesthetic Used	Times Used	Fetal Deaths	Per-Centage
1—Nitrous Oxide Ether	19	3	16%
2—Spinal	14	1	7%
3—Ether	8	2	25%
4—Ethylene	23	3	13%
5—Cyclopropane	94	12	12.7%
6—Local	4	0	0%
7—Sodium Pentothal	1	0	0%

At the present time, when we use cyclopropane, the patient is prepared for operation and draped before the anesthetic is started. In this way the baby receives a minimum amount of anesthetic.

INDICATIONS

1. Cephalopelvic Disproportion.

There were thirty-eight cases operated for this cause.

At the present time, 30 to 50 per cent of all sections are done for this indication. It should be emphasized that a contracted pelvis in the absence of disproportion is not an indication for operative intervention. W. J. Dieckmann,[1] of the Chicago Lying-in Hospital, states that it is their practice to perform an elective cesarean if the true conjugate is less than 8.0 cm. or the transverse diameter of the outlet is less than 7 cm., with the baby estimated to weigh 3,000 grams or more. His deadline in border-line cases is 24 hours of ruptured membrane or labor.

At the present time, this is the technique used by our x-ray department to determine the true conjugate. The patient is placed laterally on the radiographic table. A special measuring device—which is a heavy steel or lead ruler with a centimeter scale cut in—is placed between the legs so that it is in contact with the vulva. This places the centimeter scale at the same level as the symphysis pubis and sacral prominence. An x-ray exposure is made centering over the pelvis. On this radiograph the true conjugate is magnified to the same degree as the centimeter scale. When interpreting the true conjugate from the radiograph, the distance is measured from the symphysis pubis to the prominence of the sacrum, then that length is set over the magnified centimeter scale on the radiograph, then the number of centimeter cut-ins are counted, which gives one the exact centimeter measurement of the true conjugate.

2. Placenta Previa.

There were thirty-three cases operated for this cause.

In most series, placenta previa was the indication to the extent of 5 to 10 per cent of the total sections done. The fetal mortality is higher in cases delivered per vagina, 25 to 100 per cent, as against 5 to 10 per cent by section.

Kellogg and Irving[2] state that the inexperienced physicians have a lower maternal mortality with cesarean section than with vaginal delivery.

The diagnosis of placenta previa should be made by vaginal examination. Visualization of the placenta by x-ray is not perfect or always feasible, nor does it give information as to the degree of previa. On vaginal examination, irrespective of the amount of dilatation, if the os is completely covered by placenta, this case should be considered a complete placenta previa, and a section done.

* Presented before the Elkhart County Medical Society, in Elkhart, on December 5, 1946.

[1] Dieckmann, W. J.: Cesarean Section Mortality, *Am. J. Obstet. and Gyn.*, 50:24-48, 1945.

[2] Irving, F.: Placenta Previa, *Am. J. Obstet. and Gyn.*, 32:36, 1936.

The vaginal examination should be done only after careful preparation and vaginal instillation of a 2 per cent aqueous solution of mercurochrome, or a 1:1000 solution acriflavine in glycerin (8 cc.). At Lying-in Hospital, in Chicago, they use 1:1000 merthiolate in glycerin.

3. Toxemia of Pregnancy.

There were twenty-seven cases sectioned for this reason.

Abdominal delivery in severe preeclampsia is performed in 4 to 8 per cent of all cesarean sections, primarily for the fetus, but frequently on strictly maternal indications. The mortality from cesarean section in the treatment of eclampsia ranges from 2 to 88 per cent. Dieckmann[1] says "Only the patient with the severe type of eclampsia and an uneffaced cervix should, after eight to twelve hours of proper medical treatment, be delivered by Cesarean section." At Lying-in Hospital, in Chicago, 14 per cent of all cases of eclampsia were sectioned. These cases should be given ether, locally, or spinal anesthesia.

4. Prolonged Labor.

Thirteen sections were done because of prolonged labor.

By far the most fatal abuse of section is found in cases of prolonged labor. Many times these patients have been in labor from 24 to 124 hours or more, have ruptured membranes, and have had moderate or marked fever.

Even the extra-peritoneal operation was not designed for the worst of these cases, for the baby is already dead, dying or badly injured, and has small chance for survival. The procedure of choice is administration of antibiotics, fluids, and vaginal delivery when dilatation is completed. Craniotomy, if the infant is dead, may hasten the time of delivery.

5. Breech Presentation.

This was the reason given in eleven cases.

Dieckmann[1] states that breech presentation in patients with contracted pelvis, or in elderly primipara with large babies, elective cesarean section is warranted.

6. Occiput Posterior Position.

This reason was given in nine cases. Posterior position is not an indication for section. These cases would probably come under prolonged labor.

7. Repeat Cesarean Section.

Five sections were done for this cause.

Rupture of the uterus has a hospital incidence of 0.05 per cent. Recent reports from maternity hospitals give an average maternal mortality of 40 per cent and an average fetal mortality of 65 per cent. In view of the high maternal and fetal mortality due to uterine rupture, and the impossibility of knowing which scars will not rupture, a previous cesarean section in general warrants a repeat operation.

8. Abruptio Placentae.

Four sections were done for this cause.

Collective reviews by Bland and Rakoff and Irving[3] reveal that the maternal mortality ranges from 0 to 18 per cent, with an average of 6.3 per cent, and the fetal mortality ranges from 55 to 100 per cent, with an average of 66 per cent. The consensus is that patients presenting evidence of deep shock, low hemoglobin, rapid pulse, a uterus larger than the period of gestation, and one in which dilatation of the cervix does not occur after the membranes have been ruptured for six to twelve hours, are best treated by cesarean section.

9. Heart Disease.

This was the reason given for three cases.

Patients who have fully recovered from cardiac decompensation during pregnancy are occasionally delivered by cesarean section.

10. Pelvic Repair.

Three cesarean sections were done for this reason.

Extensive vaginal or cervical plastic operation and previous radium application to the cervix frequently necessitate section.

11. Face Presentation.

In this series there were three of these cases.

Face and brow presentations in which dilatation is slow or fails to occur, or the head fails to engage, should be treated as cases for test of labor and section, if necessary.

12. Twins.

Two sections were done for twins.

These should be done only after a test of labor. The ideal test of labor is strong uterine contractions for one to two hours with complete dilatation of the cervix and ruptured membrane. This should occur in the first twenty-four hours of labor.

13. Obstructing Pelvic Lesion.

There were four cases.

Two to four per cent of all sections are done for this reason. Most of them are made up of ovarian cysts and myomas. One must decide at the time of, or soon after the onset of labor, the course he should take.

14. Fetal Distress.

One case in the series was for this cause.

Cesarean section does not always insure a live, undamaged mother and baby. All cases in which it is possible should be delivered from below.

15. There were seven cases with no diagnosis.

[3] Bland, Paul and Rakoff, A.: Abruptio Placenta, *Am. J. Obstet. and Gyn.*, 36:165, 1938.

HOSPITAL STATISTICS—AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY

Hospital	Years	Number	Incidence Percent	Mortality Maternal	Percent Fetal
Routh—Collective	1891-1895	83		28.00	
Routh—Collective	1906-1910	711		8.10	
Holland—Collective	1911-1920	4,197		7.20	12.0
Bannister—Collective Brit. Mat.	1928	1,763		5.80	
Winters—Collective Germany	1928	4,450		7.10	9.0
Brooklyn, N. Y.—Collective	1921-1926	1,805		7.00	8.5
New Orleans—Collective Gyn. Soc.	1921-1926	300	1.80	16.10	18.9
New Orleans—Collective King	1927-1936	1,108	2.08	5.90	10.8
Philadelphia—Collective Lull	1931	573	2.43	6.80	12.8
Philadelphia—Collective Lull	1941	594	2.88	2.46	3.3
Chicago	1940-1941	2,500	2.40	2.40	
Irving—Collective	1937	7,174		2.15	9.1
Arnold—Collective	1931-1939	15,768		4.69	8.8
Massachusetts—DeNormandie	1937-1942	11,030	3.30	2.46	
Chicago Lying-in	1931-1944	1,790a	4.74	0.61	8.7a
Chicago Lying-in	1942-1944	317b	4.28	0.00	4.4b
Boston Lying-in	1931-1936	584	2.86	3.10	8.8
Boston Lying-in	1942-1943	225	2.34	0.00	6.5
New York Lying-in	1932-1939	577	2.13	1.73	
Philadelphia Lying-in	1932-1942	1,322	5.80	1.98	8.2
Margaret Hague	1932-1943	1,837	2.67	1.52	
	*Total	6,335	3.36	1.46	
Rotunda—Ireland	1938-1940	104	1.62	4.00	6.0
Glasgow Royal Mat.	1940	206	6.70	1.00	
Edinburgh Royal Mat.	1938	77	3.70	1.30	8.1
Queen Charlotte	1942	21	0.91	0.000	9.5
Women's Hospital, Melbourne	1920-1935		0.80	6.00	

a = Fetus weighed 400 Gm. or more.
b = Fetus weighed 1,500 Gm. or more.
Coll. = Collective.
* For total.

CONCLUSIONS

1. It must be kept in mind that the mortality rate in vaginal delivery is much lower than in cesarean section.

2. The incidence of cesarean section varies widely in different institutions, somewhere between 2 and 5 per cent. Our incidence of 2.6 per cent is not excessive. The maternal mortality rate of .61 per cent is in keeping with good surgery.

The fetal mortality rate of 11.5 per cent is too high.

The fetal mortality rate should not exceed from 3 to 4.5 per cent. In well-conducted obstetric clinics it does not exceed 3 per cent.

More than two-thirds of the cases had twelve hours or more of labor before section. All were given some modification of "twilight sleep," with barbiturates and scopolamine. Later on, some had rectal ether or paraldehyde. Upon these two narcotizing depressive methods were superimposed a terminal general anesthetic. In such cases, excessive blood loss for the mother and prolonged asphyxia for the baby is self-evident. This, I think, accounts for our high fetal mortality.

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OF THE
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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

REHABILITATION PROGRAM

THE Federal Security Agency has mailed to all those on the A.M.A. mailing list a little brochure that should interest every physician, entitled, "A Message to the Medical Profession on Vocational Rehabilitation of the Disabled." It is a most comprehensive discussion of one of our greatest problems, that of getting our war casualties back into a wage-earning condition. It is also announced that this is a State-Federal Program.

Dr. Carl M. Peterson, Secretary of the A.M.A. Council on Industrial Health, has endorsed the program, as have all others to whom it has been submitted in advance of publication. Nor is this program limited to war casualties; civilians who find themselves disabled come under the category. For example, thirty-five of our states already have legal authority for rendering vocational rehabilitation services to the blind, through agencies for the blind.

The program is a comprehensive one, as we have said; it provides medical, psychiatric, surgical examinations and treatment, hospitalization, convalescent care, nursing care, dental care, et cetera. All applicants for these services must be certified after a thorough medical examination.

Any person "of working age," with a physical or mental handicap which is of such nature as to interfere with his gaining employment, is eligible under this program. Even those veterans who find they do not come under the Veterans' Administration program are eligible for these new services.

As we read the announcement, it is clear that all these services come under an individual state program and the services rendered are from legally licensed physicians in those states. Full provision is made for payment of fees for these services, these fees seemingly being most fair to all concerned.

It is declared that more than a million and a half of our population are in need of such services and that accidents, illnesses, and congenital conditions add some 200,000 to this number, annually. Two hundred thousand amputees require prosthetic devices, with many thousands of amputees being added to this list each year.

One of the economic factors of the program is reflected in the statement that the average monthly earnings of a group of those in need of rehabilitation was $24.00; after proper treatment these earnings averaged $147.00.

Such is the outline of a new program, one we believe destined to become a most popular one. Of course, the medical profession again becomes an outstanding factor in such a program—we must all lend every assistance to such a program, not as a bit of charity—for we are to be paid for it—but as a routine duty of the profession, always ready to aid in any program that will enhance our health situation. We all know of numerous cases that will be benefited by a rehabilitation program and soon we will be called upon to do something about each individual case. When that time comes we will, as usual, meet it with our utmost co-operation.

AGAIN, UNDULANT FEVER

THE JOURNAL, during the past several years, has had much to say about undulant fever; in fact, we take much pride in the fact that we have, in a manner, "pioneered" in this undertaking of arousing the medical profession to the importance of an early recognition of this wide-spread disease and its possible prevention—at least control. Two of our country practitioners, "General Practitioners," if you please, did a lot of pre-war study of this disease, recognized as being prevalent in their respective communities. We refer to Drs. Dan Urschel, of Mentone, and Neal Davis, of Lowell. These men did a lot of work on this program and their observations have been printed in our magazine and widely copied by the medical press throughout the country.

Now comes a most interesting article, an editorial in *J.A.M.A.*, for July 5, "Brucellosis," which presents a new angle to the problem, that of its economic costs. It estimates that the annual loss in milk volume, from cows infected with this disease, amounts to well over 223,000,000 pounds! This would be enough to supply the milk needs of 557,000 persons for one year!

This editorial also comments on the prevalence of the disease in humans, stating that about 4,000 cases are reported, yearly, but that since only the aggravated cases are reported it is estimated that anywhere from 40,000 to 100,000 infections occur every year.

Then we turn to an editorial in the July number of the *Journal of the Iowa State Medical Society*, which offers many suggestions about undulant fever, its prevalence, and its treatment. The writer declares that from available records it is estimated that Iowa has the largest number of reported cases in the United States. In 1946 there were reported 638 cases, with one death.

There is yet another important factor in the consideration of this disease, that of the chronic form. For some years not a few physicians refused to believe that there was such a thing as "chronic undulant fever," but these scoffers now see their error. The *J.A.M.A.* editorial, for example, points out the belief that these chronic cases outnumber the acute by a ratio of *ten to one!*

Many sections of the country are at long last awakening to the importance of this disease and the value of its early recognition and treatment. Undulant fever is unduly prevalent in Indiana and it is high time that we devote more attention to its prevalence and its possible control. Our Indiana State Veterinarians Association is duly aroused over the situation, as is our Indiana State Board of Health. All these agencies are ready to co-operate in any program that will in any way relieve the situation.

"DOG DAYS"

RABIES again commands the attention of Hoosiers, the medical profession as well as the laymen. We never have gotten over the notion that a certain season of the year carried the title of "Dog Days," and that period is with us, right now.

From time to time much agitation has been aroused over the rabies situation, but, as Mark Twain put it, in talking about the weather, "There is a lot of discussion about it but no one seems to do anything about it." We talk about rabies, we establish a "paper quarantine" in certain sections of the state, and there the matter ends. We have state laws which say that dogs shall not be allowed to run at large, if one wants to take his dog out for a stroll a leash must be used, but our observation, right now, is that there are more stray dogs in the average community than in many years past.

In some sections this is a growing menace; these stray dogs, many of them abandoned by their former owners, are turned loose in the country areas, there to forage for themselves. Not uncommonly do they form into "packs" and become, veritably, "wild dogs." We have seen such things in our time and know what such a pack can and does do.

Only recently the State Veterinarian, Dr. G. E. Botkin, brought the attention of the reading Hoosiers to this situation. He remarked that in the current season there were probably more stray dogs about the state than usual and that in several counties it had been necessary to declare quarantine provisions.

All this is well and good, if these quarantine provisions were but enforced. *And they are not!* In some of our cities we have an official "dog-catcher," properly equipped with a wagon and all that goes with it; but one wagon and one man cannot continually cover a large city.

There is a remedy for this situation, that of antirabies inoculation. It is pointed out that in Massachusetts there is a state-wide law that all dogs in that area be vaccinated, yearly, and the law apparently is enforced, since rabies is almost unknown in that state.

We have had one or more dogs for many years past and along early each year these pets are taken to the "dog hospital" for an annual clean-up, in-

cluding the trimming of toe nails and—vaccination. The expense is not at all exorbitant, but there is a lot of personal satisfaction in knowing that *your* dog is not going to be the cause of rabies in some human being.

AN OLD PROBLEM—MAYBE A SOLUTION

COMES a letter from a down-state physician, one long interested in the enforcement of our medical laws. It concerns a definite violation of our medical law by a drugless practitioner.

It seems the offender has been carrying on in the community for a long time, seemingly without interference on the part of law enforcement agencies. However, by some means or another, this man recently was haled into court and there found guilty by a jury of practicing without a license. A fine was assessed—but this chap went merrily on his way, reopened his office, and was again in business.

Complaint was made to the proper authority in such matters, but with no result. It even was suggested that an injunction proceeding be instituted —which is much more efficacious in such matters than a small fine, but the "law" said "to heck with it," and there the matter stands.

This injunction proceeding can be instituted by the local Prosecuting Attorney and none other, so we are advised. We also recall that a fee of $500 can be awarded to this official by the local court, in case an injunction is had. In most counties of Indiana this constitutes a pretty fair legal fee. But in the instance under discussion there apparently is no disposition on the part of the local Prosecutor to do anything about it—he is said to have remarked, "I am not going to do anything more to pull the chestnuts out of the fire for the medical profession."

This remark, which we often heard during a tenure as a member of the Medical Board, thoroughly arouses us; it definitely is not a matter of getting medical chestnuts out of any fire—rather is it a matter of protecting the health of that particular community. The offender, if he is at all qualified to practice his so-called profession, was entitled to licensure, under the 1927 amendment to the medical law. It is stated that this man did not testify in the hearing before the local court, but that his attorney averred that "the 1927 law was wrong and that his client was prevented from obtaining a license." This, of course, is utter nonsense; as we have stated, when these licenses were being issued, back in 1927, it so happens that we were serving as Secretary of the Medical Board. In no instance was there a permit denied to one who held most any sort of a diploma, was in active "practice" on January first of that year, and had filed proper application.

It is announced that the case has been appealed to the Indiana Supreme Court, whose decision will settle the matter.

All this has to do, of course, with the recent annual medical registration law; the State Medical Board now has plenty of funds to enforce the law and no doubt the necessary machinery will soon be put into operation. There is not one good reason why Indiana should not be free from quackery of this and of other sorts, soon.

Editorial Notes

Governor Ralph F. Gates recently made three new appointments to the Board of Trustees of the University of Indiana. Among this group is Dr. Dillon Geiger, of Bloomington. This appointment is most pleasing to Hoosier Medicine, as we long have felt that the medical profession should be thus represented on the Board and doubly so, since Dr. Geiger is an outstanding member of the profession, and long has been active in its behalf. Many of his accomplishments in his local county of Monroe, in the interests of public health, have been outstanding. We thank Governor Gates for this honor, feeling assured he never will regret having made this appointment.

Just two more years to go and we will celebrate our own hundredth birthday, plans for which already are in the making. Charlie Combs heads up a committee on the History of the Indiana State Medical Association, this committee having just about completed all its plans for that phase of the celebration. Charlie has arranged for an exhaustive review of the Indiana medical magazines, going 'way back before we really had much of an organization. This subject, by the way, is a most interesting one, as it leads up to the founding of THE JOURNAL, more than forty years ago. Immediately prior to that time there were three "major" medical journals in Indiana, two at Indianapolis and one at Fort Wayne. Hoosier medical journalism has gone a long way, these past forty years!

As showing one phase of medical progress, Dr. Louis Dublin, statistician, comments on the death rate of some of the great "killers" of years ago. He states that, not too long ago, the death rate from typhoid and from diphtheria was as high as 100 per 100,000 population. These days, he says, it is not uncommon for many cities to go along, year after year, with not a single death from either of these diseases. Tuberculosis had a death rate of 300 per 100,000 population, at one time, now it has dropped to 25 in at least 10 of our states. Cholera, smallpox, and yellow fever, in epidemic form, have ceased to be. Verily, we have made progress!

Just a reminder—along the latter part of October we will have our annual session, down French Lick way, and from all indications our registration will reach the high water mark. Better assure yourself of comfortable accommodations by writing the hotel right now; we are told that advance registrations have reached a new high.

The doctor's anniversary memorial stamp, reproducing the famous painting called "The Doctor," seems to have met with universal approval among the profession, as well as the laity. Some of our societies have gotten out a special bulletin asking all members to use these stamps on all their correspondence. Most physicians have a copy of this famous painting hanging in their office, hence it is familiar to many patients.

It now looks as though Hoosier physicians, in 1948, will have an added decoration for their cars, that of a special plate carrying the initials, "M.D." Just four thousand of these plates are to be issued, according to H. Dale Brown, director of the State Bureau of Motor Vehicles. He has the notion that such a designation might be of value to physicians, especially to those hurrying to emergency cases. So far as we know, Indiana will be the only state to make such recognition of physicians.

As of July 1 no cases of Rocky Mountain Spotted Fever have been reported in Indiana, yet it may be a bit too early to do much "crowing" about that. There still are hundreds of Indiana folk touring the west, where ticks abound and where many cases of this disease originate. Best to be on the safe side and look out for ticks—if one gets on you, remove him at once—he may be a trouble maker. Another great improvement in the touring situation is drinking water. Time was when the average tourist wanted a drink he stopped at the first clear water or spring and quenched his thirst; these days, most folk who want a drink of water also want to know where the water came from.

One of our members, a former president of the Indiana State Medical Association, was so enthused by the Centenary Celebration of the American Medical Association that he returned to Indiana with the most grandiose ideas of what we should do when we reach the century mark. According to this man, the Atlantic City party would be a third-rater, as compared to what he would do, right here in Indiana. Our own Charlie Combs, however, is taking full charge of that program and for two or three years past has been planning, planning, then doing some more planning. Knowing Charlie as we do, we are certain he will come up with something good.

The Johnson County Hospital, at Franklin, recently was dedicated, the dedicatory address being delivered by Dr. Floyd T. Romberger, President of the Indiana State Medical Association.

Probably the most comprehensive report of an annual American Medical Association meeting that we ever have published appeared in our July number. This report was a compilation of the observations of several in attendance, including our delegates and alternates. It seems that each of those participating had rather a definite assignment to cover—and they did it well. Our executive secretary, Ray Smith, somewhat new to the game, seemed to be everywhere at the same time. Ray long since developed the art of being a news hawk and can "smell" a good story several blocks away.

Medical organizations seem ever to be on the increase—now we learn of a new one, one for which we have been looking for several years past—a "Medical Society Executives Conference." Rather glad to hear of its birth, too, since for many years we have felt that this group of laymen, yet so closely connected with the medical profession, never did have all their "rights." They were, on occasion, invited to sit on the sidelines and watch the performance in the "big tent," but that was about all. We recall an instance, some years ago, when informally talking with an executive of the American Medical Association, he remarked, "these fellows must be curbed, they are taking too much liberty, they are assuming too much and—they are talking too much!" Even at that time we disagreed with this man and in later years took every occasion to "prod" him about it. Later on, however, he came to agree that, after all, it *might be* that they were necessary evils, so let it go at that. Most of these executive secretaries with whom we have come in personal contact, are highly trained men, men who soon become as necessary in a medical society as any other officer. So it is that we welcome this new organization and hope that in due time they will be accorded a high place in all our councils.

MAKE HOTEL RESERVATIONS NOW!

If you have not made your hotel reservations for the annual session, do so at once. No one will want to miss this annual meeting of the Indiana State Medical Association, at French Lick, October 28, 29, and 30, 1947.

President's Page

"TO CURE A HEADACHE, YOU DON'T CUT OFF YOUR HEAD"

(An open letter)

Hon. ————,
Senate Office Building,
Washington, D. C.

Dear Senator ————:

"It's true that headless people don't have headaches, but that's a poor way to cure a headache, isn't it?"

The above phrases have been lifted bodily from a magazine advertisement discussing present-day, employee-industry relationships, and the quotations seem to have a significantly parallel bearing upon many bills introduced into the U. S. Senate during the recently past years, bills which would revolutionize American Medicine in accordance with the persuasive insistence of a certain few bureaucrats, socialists, communists, and their fellow travelers. I refer to the late Murray-Wagner-Dingell bill and its ilk, many breeds.

However well intentioned, these utopians are quite free to criticize American Medicine, carefully distorting and magnifying its faults, yet equally carefully saying nothing whatsoever of its advantages. At the same time they extol to high heaven the incredible possibilities of statism in medical practice, with studied omission of despotism's obvious delusions.

American Medicine, practiced the American Way by free men, free physicians, stands pre-eminent in the world today, unchallenged when measured by every reasonable yardstick; education, research, clinical training and facilities, availability of health and medical services, and physicians per unit of population. That these standards can and will be improved is not denied. But, how? Certainly not by the throat strangling hand of bureaucratic control or by severing the head from the corpus. Both the M-W-D bill and the Taft bill would do just that; the former with one razor stroke across the jugulars and the windpipe, the latter by slow dissection.

Quite openly you are asked to exchange our time-proven American system for old-world, fanciful, and ideological experiments which definitely are equally well known to have forced both the physicians and the peoples of those countries into the downward path leading to medical chaos, this with irreparable damage to the public weal for decades and decades, and even for generations yet to come, upon children still unborn. The lesson is plain. When a tree bears evil fruit, the more vigorous the yield the more destructive the harvest.

Let me ask: Did the Congress build the Pentagon Building? No! True, Congress appropriated the taxpayers' money for that purpose, but the building itself was erected by men who knew how, by structural engineers. By the same token, why not ask the physicians of America to write a medical care bill for the American people? They could do it. Who knows more about good medical care? They and they alone have the necessary experience.

Senator, let's talk simply. When a patient complaining of headache seeks a physician, that physician does not cut off the patient's head. No! He looks for causative factors: the brain, the spinal cord, the heart, the lungs, the liver, the digestive tract, the kidneys, the blood vascular system, or the endocrine system. One or many things in combination may be at fault. That's called diagnosis. Then the physician applies present-day therapy.

So, let's reason together. If the health of its citizens is to become a primary consideration of government, as it well may become, it would seem quite sensible to look first for the *causes* of sickness and illness and thus, by removing those causes, *prevent* sickness and illness and disability.

The physician first sees a patient because of an end result. Patients seek a physician because they are ill, sick, *an end result of some cause.* That's why they need medical care. Now, what causes sickness? Poor health? Disability? The causes are many: Insufficient food or deficient diet. Lack of adequate clothing. Exposure. Poor heating of homes. Unsanitary and filthy surroundings. Contaminated food and water. Epidemic diseases, uncontrolled. Accidents; industrial, highway, train, air, field, farm, and home. Carelessness. Poor education, so that people never are taught how to take care of what health they have, therefore ignorance. The series could be enlarged.

Too, many diseases, under proper control, can and should be prevented or wiped out entirely. Control and prevention would solve many problems of medical care. Carried to the *ultimate*, there'd be no need for medical care other than for childbirth and for the diseases of the aged, geriatrics. Toward these ends American Medicine has been struggling valiantly, unceasingly and unselfishly, generation after generation, and toward this utopia the American physicians would welcome the co-operation of our government.

But, no! Some of your colleagues seemingly prefer revolution rather than evolution. With one fell stroke they propose to destroy American Medicine as understood by us physicians. To cure the headache, they'd cut off the head. Certainly that cure would be quick and final. The corpus would cease to exist.

Sincerely,

Floyd L. Romberger

HEALTH IN EDUCATION*

W. W. Bauer, M.D.†

CHICAGO

THERE is little or no question in the modern mind that health belongs in education. Whether we consult the doctor, the educator, or the parent we find agreement that it is part of the job of our schools to prepare students for healthful living as well as for cultural or vocational success. The great question is where and how to fit this tremendous topic, "health," into a curriculum already crowded.

This is a serious problem if one considers only the matter of formal classroom instruction in health. It is generally agreed that not less than one class period a week is a minimum for health instruction at the high school level, and more time below that. This is for health instruction aside from physical activity programs usually designated as physical education. But this is far from the whole story. Health education is universally conceded to be the sum total of all impressions relating to health. This includes experiences in the home, on the streetcar or motor bus, across the back yard fence, in the restaurant, the theater, or the church. It takes in the impact of the radio, magazines, newspapers, and other reading matter. It includes exposure to superstitions, fallacies, and half-truths, which are not only entertained, but actively promoted by those with whom we come in contact.

The school is only a part of these experiences, but that part in itself constitutes a large problem. In general, the health obligation of the schools falls into three main categories, which, for want of more satisfactory terms, are generally designated as:

(1) Healthful school environment or healthful school living;
(2) The health instruction program;
(3) The health service program.

Into these three categories must fall all the concepts and motivations that we desire to impart, beginning with health knowledge and ending with a sensible desire for healthful living without hypochondriasis or fanaticism. Prevention of needless disease and accident, and the promotion of conditions for healthful living constitute a portion of the objective. Lately much has been said about special topics, such as home and family living, sex education, and mental hygiene. There has been a tendency to segregate and departmentalize these topics or areas. It seems to me that the best handling of special topics is their integration with the entire school health program.

There has been much debate as to whether health instruction as a whole should be a special course or integrated with other phases of the curriculum. The sensible answer seems to be that this is not a question of one or the other. Some of it should certainly be segregated while some can well be integrated.

In the first area, namely, healthful environment or healthful school living, are included such important considerations as location of the school for safety, for freedom from disease hazards, and regard for esthetic as well as hygienic considerations, such as odors, smoke, and the like. Plenty of safe water for drinking and washing, towels, soap, proper drinking fountains, and adequate, clean, well-ventilated toilets are essential factors which cannot be separated from the school situation as a whole. Cleanliness, neatness, and safety must be part of classroom, playground, shop, laboratory, or cafeteria operation and are vital components of these activities. The most important mental hygiene factor, namely, the emotional adjustment of the teacher to her job and to her life is so intimate a part of the classroom "climate" that there is no separating them. Hygiene of instruction involves the healthful arrangement of the school day with a wise alteration of activities. The demands of mental hygiene on the one hand and physical hygiene on the other are overlapping and inseparable.

In the health instruction field, certain phases are best dealt with in separate classes. Instruction in the structure and functions of the body, and the principles of emotional relationships and environmental influences form subject matter for classroom instruction, but they are incomplete and ineffective unless supplemented by the integrated health teaching for which opportunities are presented in the social studies, science, and the home and household arts, to say nothing of many of the cultural and artistic subject matter areas. It is probably true that health instruction suffers if it is purely an integrated subject, but it certainly suffers just as much if it is purely a special subject. Health is an aspect of living, and except for the hypochondriac or the fanatic, cannot long be separated from the larger plan of an individual's life. Health workers commonly deplore the fact that men and women wreck their health in pursuit of what the health worker regards as a lesser objective. If he were to pause and get the other fellow's viewpoint, the self-centered health educator might recognize that health in itself and for itself is an unworthy objective. Like all selfish aims, it turns to dust and ashes in the tasting. Only as a means to a greater end, as a tool in the hands of

* Abstract of address delivered at First Annual Meeting, Indiana Public Health Association, Indianapolis, June 6, 1947.

† Director, Bureau of Health Education, American Medical Association.

a builder, is good health a worthy purpose to be achieved.

Health service in the school amounts to the procedures necessary to maintain safety, prevent needless illness and promote hygienic living. The inspection and evaluation of some of the environmental factors such as lighting, ventilation, and sanitation constitute a part of health service. But ordinarily this phase is used to indicate the work of doctors, nurses, and other school personnel in excluding from contact with the other children those who have unsightly or contagious skin diseases, acute communicable diseases, or vermin infestation. Health examinations at stated intervals and upon referral, plus the follow through to interpret such examinations and the recommendations which grow out of them are also an important part of health service.

That these areas overlap at numerous points is obvious to the most casual observer. They touch upon the home at many points and make contact with other community agencies, notably the Public Health Department and the social and welfare agencies. To be effective, health in education must be a co-operative venture with school personnel, health department staff workers, voluntary agencies, the entire personnel of the home, and the family physician, forming a harmonious, well-co-ordinated, well-informed team. Anything less than that should be regarded as unacceptable.

VOICE OF MEDICINE

A LITTLE APPLAUSE

To The Editor of THE JOURNAL of The Indiana State Medical Association:

May I compliment the editor on his statement in his June editorial on the most urgent problem confronting the medical profession today? We, like the rest of America, have a decision to make; and we, like the rest of America, must chart our course for the long haul. In Indiana today a qualified, proven competent physician can secure a license for his private hospital only after conforming to regulations and requirements of "standards" as set out by a lay board, whose arbitrary and unscientific demands are backed by a wisely written but poorly administered state law. The administration of the law is based on "what you doctors have chosen for yourselves." This happens to be the rules and regulations as found in the American College of Surgeons pamphlet—over which we have no control, not even consultatory discussion.

If any hospital is to be licensed by the state now it must meet endless qualifications that have nothing to do with service to the sick, but do affect the cost of service most unfavorably. This cost is directed along the line of increasing lay administration, lay censorship in lines of science, and toward the growing regimentation of the hospital staff for the selfish benefit of the few doctors over the many. The free practice of our science is fast disappearing, and some younger men think this is justified by the bad behavior of some of us older men in times past. This is the result of the layman-like attitude of the American College of Surgeons, who modestly claim that the chaos in our profession working in Indiana hospitals was appalling in the days before the College went to work improving our standards. My experience and memory tell me that this attitude is an intolerable impertinence.

Indiana is in a mess. By the tenth of each month now the diagnosis of every patient entering a hospital the previous month must be registered in the State Board of Health, for instance. Words can be used to justify this, but we saw this moral and mental dishonesty throughout the New Deal in covering evil intent with grandiose aura, as the editor so well expressed himself. That this invades the privacy of our fight against unpleasant illness is of no consequence to lay bureaus; that this has no benefit to the treatment of disease is beyond them.

We do ourselves harm, unwittingly. Any group of doctors, more than one, in assemblage, can take over any meeting and give rise to a pleasant evening and a stimulating conclave. The laymen in our midst today, acting through the American College of Surgeons minimum standards booklet, demand our periodic and regular attendance at hospital staff meetings and take that attendance to see that we report correctly. Then they sit back smugly to ask us if we do not enjoy our meetings.

The layman attitude in our midst, encouraged by controls and compulsion advocated by the American College, has reduced the dignity of our profession to codification, to the censorship of diagnosis, therapy, and a debate on the merits of staff men of hospitals as measured by studies of charts.

What matters the initials? Today Americans are fighting to control the regulation of labor. It seems that our people have found it harmful to give to one controlling union the power to demand an initiation fee for all workers, a control over that worker's work toward ultra specialization, and a regimentation of the individual so that he has no effective voice. Why damn the CIO? We have

a parallel in the organization of our profession through our A.M.A.

Is it right that a physician must belong to the A.M.A., through his state and county societies, in that order, before he can be permitted to practice in a hospital? In all American life competition has been the stimulus toward excellence. The A.M.A. has no competition, and it is too well known that no organization or group of men, given control over others, has remained benevolent forever. We see our A.M.A. permitting and encouraging the activities of the few who would control the many, without democratic vote or voice. We see the pigeonholing of the California delegates appeal for relief from regimentation; we see a parallel in our local and state organizations where maneuvering from council to committee stifles the voice of the overwhelming majority. When a professional society turns from science to political or business interests, competition is needed for the safety of the many who choose to remain devoted blindly to their science and so are easy victims for the power hungry few.

Words can be found to justify the fact that all medical papers must be prepared in such form that they will conform to a fixed set of rules governing the mere construction of them. This has been an accepted practice or imposition for some years. I believe it is fair to take the position that some of the sterility of thought found too frequently in current literature may spring from the fact that a busy man not endowed with tax-paid stenographers finds this required adherence to form too much of an obstacle to bother reporting his very worthwhile experience or practical research.

The growth of bureaucracy in our societies and associations has brought into being the bureaucrats philosophy in the organizations. A few men, headstrong, have charted our path toward certification and over specialization so that now we are no less ludicrous and unbelievably pompous than the Hollywood madhouse. There one organization member is certified to move flowers on a stage set, but may not move a chair. In the booklet on "Minimum Standards" we have demarcation lines parallel to this delirium.

Today is no time to "view with alarm." We must act. We must have the understanding and sympathetic aid of informed laymen. We must get rid of the other kind of laymen, who, through our Boards of Health, socialized and subsidized doctors, blind zealots, social service evangelists, and the amazing maelstrom of unscientific persons, dig deep into our pockets to save 30 per cent of cancer victims, to wipe out infantile paralysis, to relieve the mentally sick that once were called criminal, and to improve the standards of our profession. Currently, I read that an automotive engineer has been so successful in developing an individual wheel suspension that he now will devote some of his time to the conquest of cancer.

Today is no time to sit back in obscurity. We alone have the right to speak with authority on our problems of hospital management and licensure, the problems of sanitation and public health, the routes of research into disease problems, the methods which must be provided for the education of good men into our good calling regardless of financial backing. We have no right to allow the American College of Surgeons to speak with apparent authority, any more than any union has the right to permit foreign racketeers to dominate the silent majority. An open shop in science is a necessity. The individual, working unhampered, has raised our standards of knowledge and practice to today's high peak. Regimentation has brought the Dark Ages before now, and one has to look at the panel system in England now to see what a centralized control of our profession will turn toward. Concrete examples of loss to the chance of giving that extra service to the patient that has stamped American medicine as unique can be had in Indiana now.

Today, in Marion county, we have no specialist produced by the American College or the American Boards. Many of our top specialists will not apply, nor could they pass. Here, an abdominal surgeon, asked on the American Board exam how to set a fractured olecranon, should in all honesty answer that he would call one of our many, very good orthopedic surgeons. That is unsatisfactory to the Board, but the American College says that you can not have an abdominal surgeon set the fracture and the resident in the hospital may refuse to assist, and yet the A.C.S. holds that certification is a must after January, 1947. So, if you pass, you must say that you would do what you had better not if you want to practice.

So it runs, on and on, today. There are countless wrongs, bureaucratic controls, skyrocketing offshoots from sensible behavior; and every issue of the State Journal could be devoted to the discussion of different material of this sort requiring attention, as your editorial pointed out so properly. Right now it is time to begin action, rather than just look at the mess.

Our county medical societies are basic units of doctors organization. It is recommended that each society in our state association instruct its delegates to the coming state convention to formulate an aggressive plan for control of our practice of medicine in this state.

No plan coming from outside source, claimed to "improve the standards of physicians and hospitals," has been proven to be worth the evil that springs from its accompanying regimentation, restriction of service, limitation, and hampering paper work that we are having thrust down our throats. The scheme of national standardization and certification of internships sounds fine—but have now proven to be punitive weapons through which other goals, not good, are secured. State control of internships, censored closely by locally

practicing physicians, is needed. Strangely enough, this sensible change is the one solution to all the problems brought to us. This will put the doctor in charge of his profession, and all others have shown themselves unfit to exercise any degree of this control. Either we take over for the benefit of humanity, or others take over to the detriment of humanity. This is history, and has been written more than once.

It is recommended that we, the members of the Indiana State Medical Association, working through our delegates, in truly democratic fashion, take over the mechanism for identifying our doctors as we know our own needs to be, and with a clear eye to our past. The California State Association delegates to the A.M.A. offered a resolution aimed at this, and this has been lost in a pigeonhole; the bureaucratic way of effecting minority rule with the majority to take the odium. It is time that our officers give heed to our wishes and work to that end, regardless of their personal convictions. Failing this, it will be well for state associations to give thought to the formation of a competitive national association, as a means of avoiding a fight in the Federal Criminal Court or a State Legislature. Aroused doctors, in the majority in Indiana, California, Ohio, and Minnesota, are bent on securing relief. Perhaps it is time that we eliminate the union closed shop requirement that every doctor practicing in a hospital must be a member of the society or A.M.A.

If a dignified study is made of the needs of the future, and all self aggrandizement is washed from our officers, boards, committees, etc., we will eliminate the hateful immaturity of limitations, certifications, grades in the "Colleges," rigid route of approach to any specialty, foreign control of internships, and other improprieties. A strong stand must be taken by the state association toward an unrelenting, aggressive representation of what the great majority of practicing doctors know to be best for our profession. There is no other group of men so well qualified to speak for themselves, and for the humanity they serve.

Thomas B. Noble, Jr., M.D.

MEDICAL PROGRESS BRINGS MEDICAL PROBLEMS

Yesterday American medicine celebrated its hundredth anniversary.

Today American medicine faces *tomorrow* with a confidence built on a firm foundation of a *century* of medical progress and achievement.

Dedicated to the great American ideals of the right of each individual citizen to "life, liberty and the pursuit of happiness," the American doctor occupies a key position in America's future.

"Life"—His task is to make the lives of others last as long and as free from illness as possible.

"Liberty"—He is battling to maintain that liberty which he feels is so necessary for himself and his fellow Americans.

"Pursuit of Happiness"—His Ten Point Program for the health of the American people is his guarantee of public service.

To assist in translating these ideals into practicalities is the job of each individual doctor and the best way to do this is through active, informed, functioning, progressive, united county medical societies. Here are some of the medical organization problems developed by the Atlantic City session:

1. Preparation of the profession for national emergency—creation of Council on National Emergency Medical Service—this council will work with state and local councils and committees.

2. Veterans Home Town Medical Care Program—meeting to be called soon in Chicago of state medical society representatives to discuss program with AMA and Veterans' Administration officials.

3. Health Councils—Promotion of these councils and integration of these councils with rural health councils. Over-all picture of health councils will be given in forthcoming News Letter.

4. United Mine Workers' Health and Hospital Fund—This will be subject of joint meeting of Councils on Medical Service and Industrial Health with Board of Trustees.

5. Cancer Control Funds—Much progress has been made in devising a policy in reference to cancer control funds. This subject may well be a special study by each county and state medical society.

6. Compensation for Loss of Wages During Sickness—Developments in this field are being watched carefully by many state medical societies. Keep track of Crosser legislation, and developments in California and Rhode Island.

7. Diseases of the Chronically Ill—Broad program approved (in principle) by House of Delegates. As in the cancer field leadership in developing local programs can best be taken by the county and state medical societies.

8. Health Centers—Specific recommendations concerning health centers as provided under the Hill-Burton Act were approved by the House of Delegates. In the making is a study of the regulations and rules promulgated in Washington for construction of health centers and hospitals which are said to be such that these facilities cannot be made available to those rural communities needing them most.

9. Group Practice—A study of group practice is to be made by the Judicial Council and the Councils on Medical Education and Hospitals, Industrial Health and Medical Service, Bureau of Medical Economic Research and the Bureau of Legal Medicine and Legislation. This will be no small task in view of the fact that a recent survey of the U. S. P. H. S. shows 368 groups participated in by 3,084 physicians in the United States.

10. The "G. P."—From the preliminary "Grass Roots" Conference held the day before the regular convention started to the final acceptance talk by President-elect Sensenich, just before the adjournment of the House of Delegates, the General Practioner was the outstanding theme. Recognition of his importance snow-balled into gigantic proportions resulting in the arrangements for a semiannual meeting of the A. M. A. this coming December for the General Practitioner.

A. M. A. News Letter.

INSTRUCTIONAL COURSES

at the

1947 Session of the Indiana State Medical Association

French Lick Springs Hotel

TUESDAY, OCTOBER 28

The organization of the courses in basic medical topics is complete and it will be possible for you to register for your choices from the class schedule to be published on this page in the September JOURNAL.

Twenty-five courses will be offered. They will be so scheduled that you can attend as many as five. You can select a course covering those facets of medicine in which you are most interested. The classes will be limited to thirty members. An opportunity for question and open forum will be available over each subject. This is real instruction!

The classes will begin at 11 A.M., 1 P.M., 2 P.M., 3 P.M. and 4 P.M. Each will last fifty-five minutes. The classrooms will be grouped to facilitate change of rooms as necessary. Experience is making these courses a "must" on the program of many of the association members. All courses were closed to additional students by class time at the 1946 session and the majority were closed by mail order prior to October 1.

Send your reservation for a room at French Lick NOW and be ready when your September JOURNAL comes to select the courses you want and mail your reservation promptly for your

INSTRUCTIONAL COURSES

at the

1947 Session of the Indiana State Medical Association

French Lick Springs Hotel

TUESDAY, OCTOBER 28

The Committee

Gordon W. Batman—Russell A. Sage, Co-Chairmen
Floyd T. Romberger, Jr.
Frank Ramsey
J. Lawrence Sims



Indiana Medical Men at Work

A WHALE OF A CONVENTION IS IN THE MAKING AND WHAT A WHALE OF A JOB IT IS

Your annual Indiana State Medical Convention does not just happen or grow up like "Topsy." It is the organized and coordinated effort and result of INDIANA MEDICAL MEN AT WORK.

Busy men, prominent leaders of the medical profession from every section of the state, giving many hours of their valuable time over a period of nine to twelve months, promoting and perfecting a three day program of scientific progress, discussion, instruction, information, and exhibits, interspersed with appealing entertainment, relaxation, good fellowship, and professional relationship.

YOUR 1947 FRENCH LICK MEETING A MASTERPIECE OF MEDICAL MEN AT WORK

Before last year's convention ended there were men at work on the 1947 session. The state officers, executive committee, the council, the executive secretary, and the association headquarters staff immediately started outlining plans and policies, and mobilizing personnel and facilities for this year's annual meeting. A tremendous amount of preliminary detail and ground work was soon accomplished, the three main convention committees on Scientific Work, Scientific Exhibits, and Convention Arrangements were organized, and a "whale of a convention was in the making."

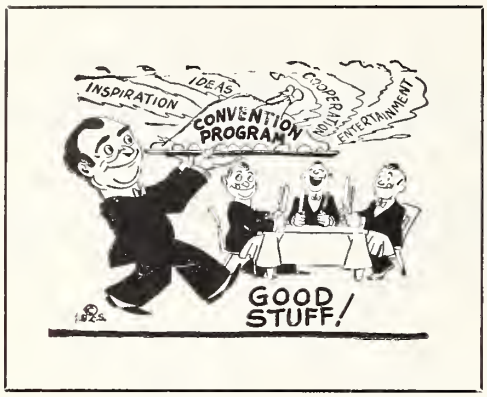
BEHIND THE SCENES

The Committee on Scientific Work, (Dr. O. A. Province, of Franklin, chairman, Dr. E. Rogers Smith, of Indianapolis, and Dr. Ralph U. Leser, of Indianapolis), meeting jointly with the officers of the Section on Surgery, (Dr. Arnold Duemling, of Fort Wayne, chairman, Dr. William Niles Wishard, Jr., of Indianapolis, and Dr. Harold D. Caylor, of Bluffton), Section on Medicine (Dr. William M. Dugan, of Indianapolis, chairman, Dr. Maurice E. Glock, of Fort Wayne, and Dr. Stanton L. Bryan, of Evansville), Section on Ophthalmology and Otolaryngology (Dr. R. R. Calvert, of Lafayette, chairman, Dr. Robert A. Smith, of New Castle, and Dr. R. P. Good, of Kokomo), Section on Anesthesia (Dr. Frank W. Ratcliff, of Lafayette, chairman, Dr. William H. Lane, of South Bend, and Dr. Edward F. Bloemker, of Indianapolis), and the Section on General Practice (Dr. Claude S. Black, of Warren, chairman, Dr. Clay A. Ball, of Muncie, and Dr. Eugene F. Boggs, of Indianapolis) went into an all-day huddle on March 30, planning an extensive three-day scientific program in keeping with the modern trends and the rapid developments in the field of medicine:

TUESDAY, OCTOBER 28—A full day of instructional courses.

WEDNESDAY, OCTOBER 29—Morning, General Scientific Meetings.
Afternoon, Section meetings with lectures and panel discussions.

THURSDAY, OCTOBER 30—A full day of General Scientific Meetings climaxed by the Annual Banquet at night.



TIMELY MEDICAL SUBJECTS: Symposium on "The Treatment of Burns," "Brucellosis," "Recent Advances in Therapy of Coronary Disease," "The Paradox: Psychoneurotic Malingering," "Treatment in Early Stages of Poliomyelitis," "Use of Streptomycin in the Treatment of Tularemia," "Modern Treatment of the Anemias," and "Early Diagnosis and Treatment of Cancer," are a partial list of the up-to-the-minute subjects selected for the General Scientific Meetings on Wednesday and Thursday.

GUEST SPEAKERS OF NATIONAL NOTE include Henry Nelson Harkins, M.D., Professor of surgery, University of Washington School of Medicine, William Shainline Middleton, M.D., Dean and Professor of Medicine, University of Wisconsin Medical School, Alexander Robinson MacLean, M.D., Rochester, Minnesota, Philip Lewin, M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School, George Thomas Pack, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College, Lee Foshay, M.D., Professor of Bacteriology, University of Cincinnati College of Medicine, Bruce Kenneth Wiseman, M.D., Associate Professor of Medicine, Ohio State University College of Medicine, and several others of equal prominence in American medicine.

SECTION MEETINGS. Wednesday afternoon of the convention will be devoted to meetings of the five special sections of the association. The meetings will convene simultaneously in separate halls in the French Lick Spring Hotel. Several of the above named guest speakers will also address the section meetings, and many other state and national medical leaders are on the section programs. The complete program of lectures, symposiums, and panel discussions for the section meetings will be published in the October issue of your JOURNAL.

SCIENTIFIC AND TECHNICAL EXHIBITS

The entire mezzanine floor of the French Lick Springs Hotel has been reserved for Technical Exhibits and every inch of space has been sold, thanks to the excellent planning and salesmanship of our executive secretary, Ray E. Smith. It will be the largest technical exhibition we have ever presented at French Lick.

The Scientific Exhibits will be located on the foyer to the Main Convention Hall. Chairman J. L. Arbogast, M.D., James N. Collins, M.D., and Kenneth G. Kohlstaedt, M.D., the committee in charge, have reserved ample space and ideal locations for this department and are this year inaugurating awards of merit certificates to the scientific exhibitors. There is every indication that the scientific and technical exhibits will be a big feature of the Convention.

INSTRUCTIONAL COURSES. Dr. Gordon Batman and Dr. Russell A. Sage, co-chairmen, Dr. Floyd T. Romberger, Jr., Dr. Frank Ramsey, and Dr. J. Lawrence Sims, all of Indianapolis, the committee in charge of these courses, are literally bringing "A Mobile College of Medical Knowledge" to French Lick for one day, Tuesday, October 28. An intensive postgraduate course, with twenty-five classes teaching up-to-the-minute medicine of special interest to the doctor who wants to know "What's new?"

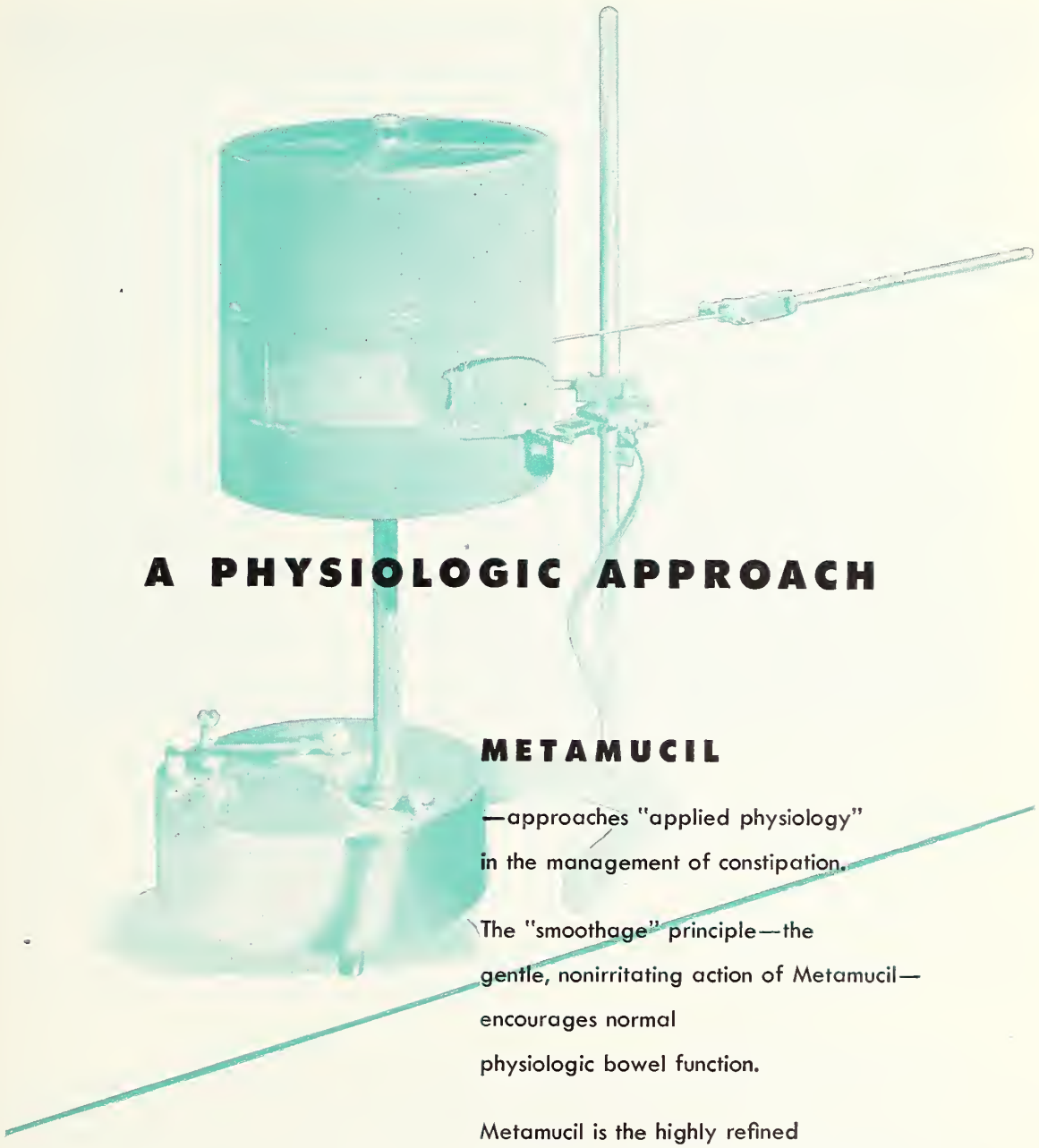
See special announcement on Instructional Courses in this and subsequent issues of your JOURNAL.

YES: INDIANA MEDICAL MEN ARE AT WORK ON A WHALE OF A CONVENTION

This is the third of a series of previews on your 1947 Convention issued by

Your Hosts,

The Orange County Medical Society.
The Third District Medical Society.
The Committee on Convention Arrangements.



A PHYSIOLOGIC APPROACH

METAMUCIL

—approaches "applied physiology"
in the management of constipation.

The "smoothage" principle—the
gentle, nonirritating action of Metamucil—
encourages normal
physiologic bowel function.

Metamucil is the highly refined
mucilloid of Plantago ovata (50%),
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combined with
dextrose (50%) as a dispersing agent.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Medical Panorama by the Associate Editor

KENT COUNTY (Michigan) has appointed a committee to meet with a similar committee of pharmacists to iron out various problems affecting both. This followed a discussion in which the pet peeves of the two professions were aired in open meeting. Good idea.

———ISAM———

TENNESSEE, after several years of battling with a malignant naturopathic act, passed in 1943, has at last been successful in eradicating all naturopathic laws from their statute books.

———ISAM———

SANGAMON COUNTY (Illinois), irritated by disregard of pedestrians for autoists' rights, advocates a careful physical examination for autoists and all pedestrians before they are allowed out of the house. Think Congress should pass a law. "Shouldn't cost more than about 5 billions a year, either." Shucks! It's cheaper to hit 'em.

———ISAM———

NORTHWEST MEDICINE warns physicians against entering into agreement to service employees enrolled in private hospital associations in a single industry, citing the example of the Telephone Employees' Hospital Association of Oregon, Inc. Indicating that plans of this kind are posing a rising threat, a careful analysis is given of the pitfalls such arrangements entail. The end result is that "those gullible doctors who swallowed the bait are in a one-way deal, selling both themselves and their colleagues down the river of cut-rate medicine to ultimate disaster."

———ISAM———

SAN DIEGO calls attention to the following: "It is necessary for only three Republicans on the Senate Labor and Public Welfare Committee (formerly Education and Labor) to join the Democratic members of this committee for a majority vote. Already Senators Morse and Aiken, both Republicans, and both members of this committee, have indicated that they are likely to go along with the Democrats on matters of so-called liberal legislation."

———ISAM———

ALAMEDA COUNTY (California) announces a 10 per cent reduction in premiums on their group malpractice insurance coverage, this in addition to the lowest group rate cost in the country and the further advantage of having written their own insurance contract. They are covered by the American Mutual Liability Company.

FLORIDA hopes to establish a School of Medicine. The Board of Governors of the state medical association have approved such a step and will endeavor to secure public support of such an institution. Another item reports the selection of a Director of Public Relations.

———ISAM———

JACKSON COUNTY (Missouri) asks: "Are We Going or Coming?" Reasons for the query: The temporary setback only of tendencies toward socialistic institutions. The unrealized claim that "given adequate time, we, the medical profession, could work out the medico-economic problems of the nation." The fading sponsorship of a member of the Cabinet for health. The groping endorsement of prepayment hospital and medical care programs. The stagnant progress of the A.M.A.'s Ten-Point Program. The editor is "reminded of the fly on the chariot wheel gleefully exclaiming, 'My, what a dust I do create!' "

———ISAM———

AROUND THE WHEEL. No action on national health plans this year. CALIFORNIA compulsory health bill tabled and lost. Cash sickness insurance defeated in MASSACHUSETTS. NEW JERSEY benefit proposal delayed. Compulsory state health insurance proposed in WISCONSIN. MAINE has been stymied, for the present, in seeking legislative action to establish a medical school. They were also unsuccessful in securing passage of an enabling act for voluntary prepaid medical care. HAWAII defeated several measures aimed at compulsory sickness insurance.

———ISAM———

MONROE COUNTY (New York) abstracts an address titled: "Medicine Accepts the Collectivists' Challenge." If you think the Republican victory has in any way slowed the efforts of the proponents of compulsory health insurance, there are many items noted that will change your mind. The proposed compulsory plan for the territory of Hawaii, the Health Care Benefits of railroad workers, sick care for dependents of veterans, a school health program, investigations and health surveys with the idea of finding needs for facilities and governmental aid, proposing the same bills under different titles, proposal of frequent bills, coverage of smaller groups, and many other subterfuge measures are being utilized to accomplish the purpose piecemeal. A plea for continued vigilance and action, backed by thorough knowledge of the facts, is made.



The "sense of well-being" so frequently reported by patients following "Premarin" therapy often means the difference between an active, enjoyable middle age and a sedentary one. Not only prompt relief from distressing menopausal symptoms but also a brighter mental outlook which may be translated into a desire "to be doing things"...such are the results which may usually be expected following "Premarin" administration . . . therapy with a "plus."

"Premarin" provides effective estrogenic therapy through the oral route with comparative freedom from untoward side effects.

"Premarin" is available as follows:

Tablets of 2.5 mg.....bottles of 20 and 100.
Tablets of 1.25 mg.....bottles of 20, 100 and 1000.
Tablets of 0.625 mg.....bottles of 100 and 1000.
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful).....bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water-soluble sulfates. The water solubility of conjugated estrogens (equine) assures rapid absorption from the gastrointestinal tract.

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What's Going On In Indiana by the Executive Secretary

State Fair Exhibit. Chairman Robert H. Wiseheart of the Committee on State Fair has procured two of the choicest American Medical Association exhibits for the Indiana State Medical Association's space at the Indiana State Fair. One is on heart disease and the other is on hay fever. An attractive booklet in nursery rhyme style has been printed to distribute to youngsters who visit the booth. Too, arrangements are being made to do blood pressure tests. This has been a feature of other years, but it still retains its popularity. Last year 4,260 tests were made and cards were given to abnormals with the suggestion they go to their family physicians for further study. Incidentally, the fair will be held August 29 to September 5, inclusive, and the ISMA booth will be in the Educational Building. A member of the Committee on State Fair will be in charge of the exhibit each day. While attending the fair, drop in and say hello.

——ISMA——

Fifty Years in Practice. To practice medicine for fifty years or more is a long, long time, and Indiana physicians who have served this many years are going to be recognized by the state medical association. The Executive Committee has voted to present an appropriate lapel emblem and a certificate of appreciation to these veterans at the annual session at French Lick in October. The awards will be made each succeeding year. The names of the recipients will be obtained through the secretaries of the county medical societies. This is well deserved recognition for these older physicians. Undoubtedly the members of the "Fifty Year Club," as one might call this group, will get together at the annual sessions and have a grand time reviewing their professional experiences. Hats off to them!

——ISMA——

Bursting at the Seams. The American Medical Association, with its 132,000 members, has grown so large that few cities are equipped to take care of its annual sessions. Two things are required—an enormously large hall to accommodate the scientific and commercial exhibits, and thousands of hotel rooms. The 1948 meeting, for instance, was to have been held in St. Louis, but had to be switched to Chicago. New York City was the choice for 1949, but it was reported that exhibit hall space could not be leased for the necessary dates and so Atlantic City was selected for 1949, and San Francisco in 1950. Due to the fact that Chicago is so near . . . and it will be there next June that our own Doctor Sensenich will be inducted into the presidency . . . Hoosier physicians will be attracted to the 1948 AMA session. June 21 to 25, inclusive, are the dates. A step has been taken to relieve the congestion at the annual AMA meetings and to make its fine scientific programs available to more physicians by holding the supplemental sessions of the House of Delegates (held previously in Chicago each December) in various sections of the country and augmenting them with scientific lectures devoted exclusively to subjects of interest to the general practitioner. Time and place for the first such meeting have not been set.

——ISMA——

ISMA Has a Problem, Too. In its ninety-eight years the Indiana State Medical Association has grown to the point where only two sites in Indiana are recognized as adequate for the annual sessions —Indianapolis and French Lick. Not all doctors can get accommodations in the French Lick hotel now and many must stay in smaller and far less luxurious hotels in French Lick and West Baden. This will be true this fall, but since a coffee shop has been opened in the big hotel, outsiders will have a convenient and moderate-priced place to eat. The hotel at the southern Indiana spa is short on public meeting rooms, making it difficult to take care of all groups satisfactorily. In view of the situation, suggestions have been made that the Indiana association, somewhat like the AMA is doing, hold its annual session proper in Indianapolis, and arrange a supplemental meeting at French Lick where outdoor sports and entertainment would predominate. Many doctors and their wives like to go to French Lick for relaxation, but Indianapolis, after all, is much better equipped to handle exhibits and scientific meetings. Under the plan suggested, it is argued that everybody would get what they liked.

——ISMA——

A Little of This and That. Ten district society meetings were held in May and June. Dr. Floyd T. Romberger, president, or Dr. Cleon A. Nafe, president-elect, were present at all of them except one, which was held while they were attending the A.M.A. centennial session in Atlantic City. . . . Dr. Walter L. Portteus, of Franklin, has been elected president-elect of the newly-organized Indiana Public Health Association.

The subject is: Allergy

The advice, as usual, is: "SEE YOUR DOCTOR"

In LIFE and other national magazines, Parke-Davis presents a timely message about allergy (shown below). It appears in full color . . . reaches an audience of nearly 23 million people. It is No. 206 in the "See Your Doctor" series published in behalf of the medical profession.

Some things you should know about allergy

No. 206 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



MEDICAL science has discovered many interesting things about allergy.

If today you tell your doctor that you suffer from asthma, sneezing attacks or itching eyes, one thing he considers is the possibility that you may be allergic—which means that you may be sensitive to some substance which causes no trouble for most people.

In discovering this offending substance (known as an allergen), your doctor acts as a detective. He may ask detailed questions about the time of your attacks, where they occur, the furnishings of your home, the food you eat.

Such questions may give him clues to the nature of your trouble. If your attacks come, for instance, in the late spring or summer months and last till the first frosts, he will suspect that your trouble is due to some pollen, that you may have some form of "hay fever."

In other forms of allergy, it is not so easy to track down the offending substance. If your case is not clear-cut, your doctor must consider hundreds of possibilities.

A few grains of mustard can make some people violently ill. A man can be sensitive to his wife's face powder, or to dog hair or grass pollen, or to the cattle hair in the mat under a rug.

Simple skin tests are often used to reveal the offending substance. Drops of various extracts—of pollen, foods, and other substances—are injected into the skin or put on skin scratches. If you are sensitive to the substance being tested, a swelling will usually develop within a few minutes.

Once a doctor has found what causes the allergic reaction—by means of the history of the case supplemented by skin tests—he will prescribe treatment according to the nature of the patient's sensitivities.

If the patient is allergic to a particular food, the easiest solution is to avoid the food. If his sensitivity is to feathers, the substitution of a fibre pillow for a feather one may bring surprisingly effective relief.

If the allergen is house dust or pollen, or something else that cannot be easily avoided, a series of inoculations may be suggested.

Some people, however, do not respond to this type of treatment, or are sensitive to too many different things to make inoculations a practical procedure. New chemical drugs—developed to control allergic reactions in certain types of allergy—are showing promise. They are to be used, of course, only under the direction of a physician.

SEE YOUR DOCTOR. If you suffer from recurring and unexplained attacks of sneezing, skin rashes, or asthma, see your doctor. In allergy, as in other medical problems, your physician can give you more help today than ever before.

Makers of medicines prescribed by physicians

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News Notes

Recently discharged from the Army, Dr. Joseph L. Sheridan has accepted a residency in psychiatry at the St. Elizabeth Hospital, Washington, D.C. Doctor Sheridan started his duties there on July first.

Three Indianapolis physicians, Drs. Leroy E. Burney, Norman M. Beatty, and John D. Van Nuys, have been named by Governor Gates to the Commission for Physically Handicapped Children, a new agency established by the last session of the State Legislature. The purpose of the Commission is to study conditions relating to protection, education, and training for Indiana's physically handicapped children.

On July first Dr. K. Randolph Manning became associated with Dr. Gordon W. Batman, of Indianapolis, in the practice of orthopedic surgery. Doctor Manning recently completed a residency in orthopedic surgery at the Indiana University Medical Center.

Dr. Richard M. Nay, recently discharged from the Army after thirty months' service, has opened an office for the practice of internal medicine at 214 Hume Mansur Building, Indianapolis.

Dr. John D. Ralston, formerly of Indianapolis, has transferred his membership to the Colorado Medical Association. He plans to open an office for the practice of internal medicine in Colorado Springs.

Dr. Clyde G. Culbertson has been re-elected first vice-president of the Indiana Cancer Society. Dr. Thurman B. Rice is second vice-president, and Dr. Chester A. Stayton is third vice-president. All are Indianapolis physicians.

Dr. Clement E. Kelley has located his office at 424 East Twenty-eighth Street, Indianapolis, for the general practice of medicine.

After more than four years' service with the Navy, Doctor Robert O. Bill, of Indianapolis, is now a resident in psychiatry at the Winter Veterans Hospital in Topeka, Kansas. Doctor Bill is also taking work at the Menninger Psychiatric Foundation there.

Dr. William C. Schafer, of Decatur, and Miss Barbara Rang, of Washington, were married in Washington on June twenty-second. Doctor Schafer is a resident at the Indianapolis City Hospital.

At a meeting of the American Society for Pharmacology and Experimental Therapeutics, in Chicago, recently, Dr. Ko Kuei Chen, of Indianapolis, was elected treasurer.

Dr. J. W. Morris, of Hartford City, has accepted an appointment for one year as resident physician in the department of ophthamology at the Barnes Hospital, Washington University, in St. Louis.

On August first Dr. Robert A. Royster reopened his office in Evansville for the practice of general surgery. He recently completed a year's residency in pathology at the University of Virginia School of Medicine and Hospital, at Charlottesville, Virginia, following his discharge from the Navy.

Doctor Royster was stationed with the Marine Corps in the Pacific during the war.

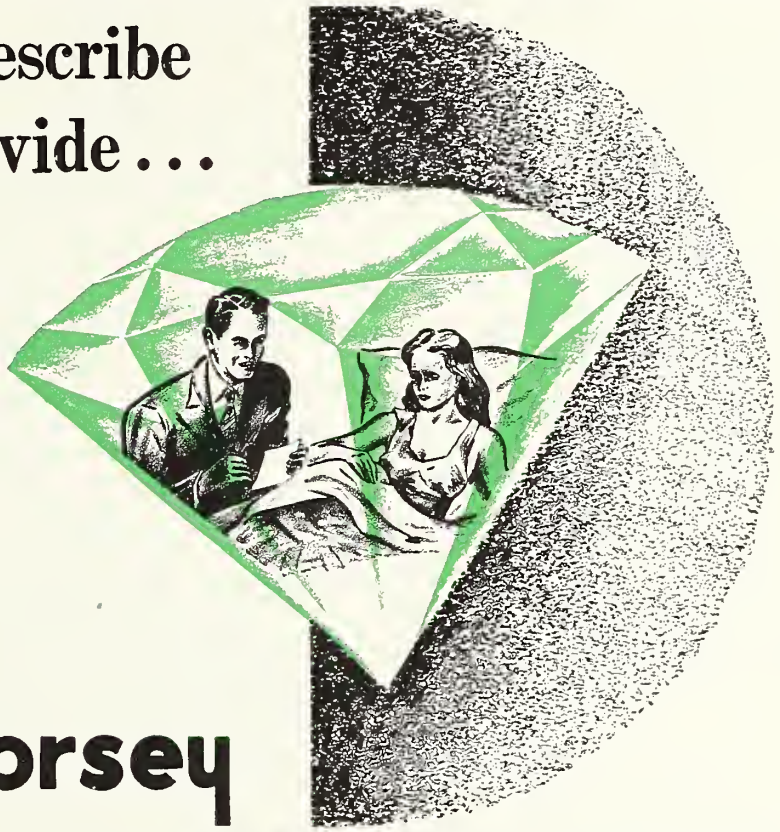
Dr. Frank B. Ramsey was awarded the Legion of Merit at a presentation ceremony in the office of Brigadier General C. M. Walson, First Army Surgeon, at Governors Island, New York, July 3, 1947. The award was given for "exceptionally meritorious conduct in the performance of outstanding services in Hawaii and the Southwest Pacific area, from 4 August 1942 to 29 January 1945." Colonel Ramsey served overseas in Hawaii, New Guinea, Leyte, and Luzon. After serving as a major with the 38th Division, from January 1921 to March 1942, he was promoted to the grade of lieutenant colonel, and at that time assigned as the division surgeon.

Indiana State Pediatric Society

In anticipation of a meeting in South Bend at the time of a Notre Dame football game an effort is being made to bring the Indiana State Pediatric Society mailing list up to date. Any physician who is particularly interested in pediatrics and would like to have his name placed on this list so that he will be notified of the time and place of pediatric meetings may do so by submitting his name and address to Dr. K. T. Knode, 729 Sherland Building, South Bend, Indiana, President of the Society.

After having served for three years with the Naval Medical Corps, Dr. Donald E. Stephens has opened an office at 6332 Guilford Avenue, Indianapolis, for the general practice of medicine. While in the Navy Doctor Stephens served at the United States Naval Hospital in New Orleans, Louisiana, and Great Lakes, Illinois, and aboard an amphibious hospital ship during the invasions of Iwo Jima and Okinawa.

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As a result of war and persecution, doctors, dentists and technicians in allied fields throughout Europe have been deprived for more than ten years of news of the latest developments in their professions. When you have finished with this issue, put it to work by sending it to the SOS (Supplies for Overseas Survivors) Collection of the Joint Distribution Committee, 1539 Troy Avenue, Vanderveer Park, Brooklyn, N. Y. It will be placed in a library in a D.P. camp, child care center, hospital or school, for use by professionals desperately anxious to bring themselves up-to-date.

WILLIAM NILES WISHARD

1851 - 1941

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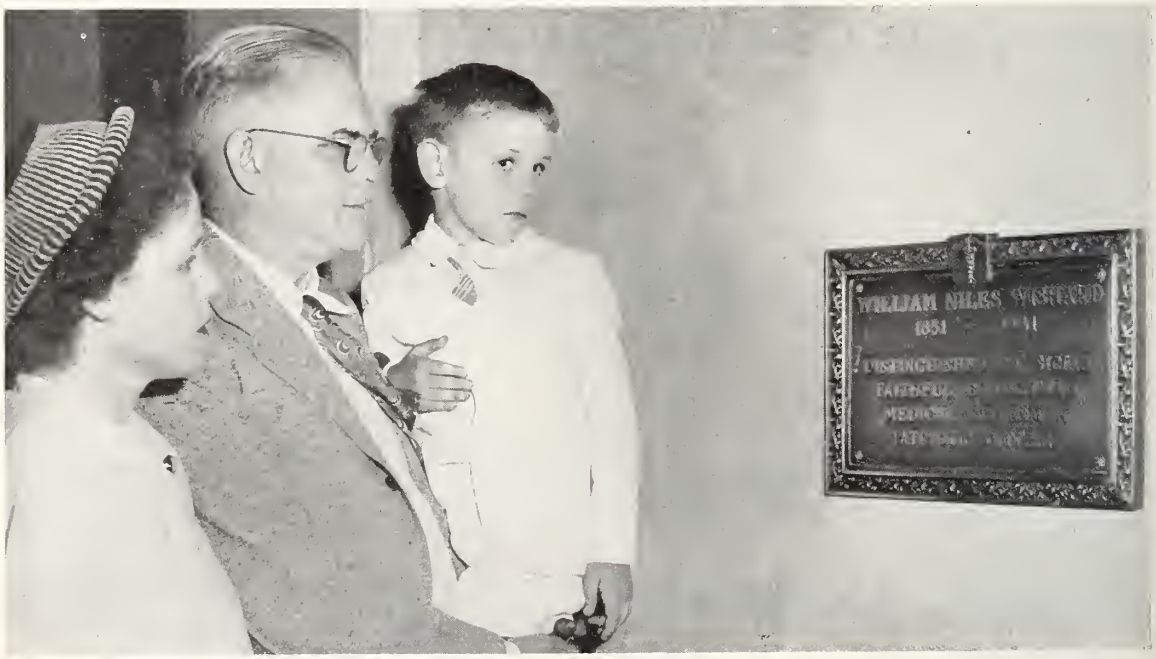
These are the words upon a bronze plaque which may be seen on the wall to the north of the main entrance to the Methodist hospital in Indianapolis. They are in eloquent tribute to the memory of one of the most beloved and distinguished members of the Indiana State Medical Association, Dr. William Niles Wishard, Sr., Indianapolis physician and surgeon.

The members of the medical staff of the hospital presented the plaque to the institution. Doctor Wishard, who died in 1941 at the age of 90 years, joined the staff at the time the Methodist hospital was opened in 1909. He was still a member at the time of his death.

The tablet was unveiled on the afternoon of June 26. The veteran physician's grandson, William Niles Wishard III, son of Dr. and Mrs. William Niles Wishard, Jr., of Indianapolis, withdrew the covering after Dr. John A. MacDonald, life-long friend, paid glowing tribute to his skill as a physician, his devotion to his God and church, his praiseworthy contribution to the state medical association, and his usefulness as a patriotic citizen. The ceremony was performed on Master Wishard's sixth birthday anniversary.

Bishop Titus Lowe, president of the board of trustees of Methodist hospital, accepted the plaque upon behalf of the institution. Dr. Roy A. Geider, hospital medical staff president, presided. More than fifty physicians and friends of the late Doctor Wishard were present at the services.

Doctor Wishard devoted many years of his life to the cause of medicine in Indiana. In 1898 he served as president of the state medical association. Upon his recommendation in 1923, the Bureau of Publicity was created by the Council. He was appointed a member of the first bureau and was still serving in that capacity at the time of his death.



Indianapolis News Photo.

Left to right, Mrs. William Niles Wishard, Jr., Doctor Wishard, and William Niles Wishard III.

Dr. Herbert L. Joseph, of Indianapolis, is now serving as resident in dermatology and syphilology at Barnard Skin and Cancer Hospital, in St. Louis.

Dr. Russell E. Havens, of Fort Wayne, has announced the opening of an office there, for the practice of anesthesiology.

Dr. Alan Johnston, of Indianapolis, opened an office for the practice of medicine in Plainfield recently. Following his graduation from the Indiana University School of Medicine, Doctor Johnston interned at St. Joseph's Hospital, in Tacoma, Washington, then entered the Army Medical Corps, serving for twenty-eight months in a veterans hospital at Portland, Oregon.

On July first a cash sickness benefit system for railroad employees began operating throughout the United States, which will probably require about 650,000 medical examinations a year. Employees are free to choose their own physicians, and any physician to whom an employee goes for examination or treatment may supply the information required as initial proof of an employee's claim. A physician's statement of sickness will be required before claims can be paid. All disabilities which prevent railroad employees from working, regardless of how or where they occur, are covered under the program. The system will be administered by the Railroad Retirement Board.

Annual Postgraduate Course

The annual Postgraduate Course for general practitioners is being offered this year by the Indiana University School of Medicine on the Medical Center campus in Indianapolis during the week of October 6. Emphasis will be placed on the therapeutic aspects of all phases of medicine.

In past years this course has attracted more than a hundred physicians from all parts of the state annually, and above normal registration for the sessions is anticipated this year. Dr. Cyrus J. Clark is chairman of the Department of Postgraduate Education at the Medical School. Inquiries regarding the course and arrangements should be addressed to: Dean's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7.

The course outlined for this year, opening Monday, October 6, and closing Friday evening, October 10, will consist of clinics, reviews, and lectures in approximately twenty fields of general value to the general practitioner. Morning sessions will be devoted to clinics, afternoons to reviews and round-table discussions, with guest speakers of note in various fields of medicine addressing the group in the evenings. As in the past, the course is offered without tuition charges.

A new physician in LaPorte is Dr. George Von Asch, who has opened an office at 912 Monroe Street. Upon graduation from the University of Illinois Medical School Doctor Von Asch began practice in Hawaii, where he remained for seven years before coming to LaPorte.

The annual meeting of the Indiana State Medical, Dental and Pharmaceutical Association was held on June eighteenth at the Hoover Building in Terre Haute. Fifty-one members attended the meeting. Dr. G. Duncan Hinkson, of Gary, was installed as president.

After being separated from service, Dr. E. J. Ettl was appointed assistant medical director of the Ames Company, at Elkhart.

Dr. William F. Hughes, Jr., of Indianapolis, has been named head of the Ophthalmology Department of the University of Illinois College of Medicine, in Chicago. He left his practice in Indianapolis and assumed his new duties there on July first.

"Dr. A. C. Arnett Day" was observed on June third at St. Elizabeth Hospital, in Lafayette, in honor of Doctor Arnett's forty years of service on the hospital staff. A testimonial scroll was presented to him by Dr. F. S. Crockett, of Lafayette. More than one hundred staff members, interns, and former interns were present, and a testimonial dinner in the evening climaxed the program.

Research Fellowships—The American College of Physicians

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1948-June 30, 1949. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from $2,200 to $3,000. Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania, and must be submitted in duplicate not later than November 1, 1947. Announcement of the awards will be made as promptly as is possible.

An intensive campaign designed to interest eligible girls in nursing as a career is coming to a conclusion in the Indianapolis metropolitan area. The drive was built around a strong, concentrated public relations campaign implemented by the Indianapolis Junior Chamber of Commerce as one of that organization's civic projects. The idea for the campaign first was broached by the Indianapolis Hospital Council which empowered a special committee to lay the groundwork. The aid of the Junior Chamber was enlisted and a committee of that organization, headed by Dr. Carl B. Sputh, Jr., is functioning.

In the Indianapolis Centennial parade floats from the four schools of nursing in Indianapolis, plus a float from the Junior Chamber, depicted various phases of nursing.

This was followed with newspaper and radio publicity dealing with the acute need for nurses, appeals carried in the advertisements of Indianapolis department stores, a proclamation by Governor Gates decreeing "Nurse Enrollment Week" for August 3-10, poster displays, and direct contact work.

The Indianapolis Junior Chamber, meanwhile, interested other chapters of that organization throughout the state and similar publicity in the respective localities was arranged for.

A special appeal has been made to physicians to interest likely prospects in nursing as a career. It has been pointed out that, while the need for additional hospital beds is acute, the need for nurses to staff those beds is just as great.

NOBEL PRIZE WINNER GUEST SPEAKER AT EARLHAM CENTENNIAL CELEBRATION

Dr. Wendell M. Stanley, 1946 Nobel Prize winner in chemistry, will be a speaker at two of the main sessions of the four-day Earlham College (Richmond) Centennial Anniversary Celebration, September 19 to 22.

Dr. Stanley, it will be remembered, is famous for "the isolation and characterization of a variety of viruses affecting plants, bacteria, animals, and man in the form of characteristic and distinctive materials, all at least as complex as nucleoprotein." He is noted also for "fundamental studies on influenza virus and development of efficient method for production of centrifuge-type influenza virus vaccine, now available for civilian use."

Dr. Stanley, who graduated from Earlham in 1926, is now a Fellow at the Rockefeller Institute for Medical Research. He is one of two Nobel Prize winners who attended Earlham. He was named for "achievement preparing enzymes and virus proteins in pure form."

He will give an illustrated address on Friday, September 19, at 8:15, at an invitational assembly of physicians, surgeons, and scientists, to be held in his honor. It will be in Goddard Auditorium, Carpenter Hall, Earlham College, Richmond. His subject will be "Studies on Purified Influenza Virus."

Invitations are being sent by the college, and by a Richmond committee of doctors, to members of the Indiana and Ohio State Medical Associations within a limited radius of Richmond. Anyone interested in receiving an invitation may have one by writing the Centennial Celebration Committee, Box 87, Earlham College, Richmond.

A buffet dinner will be served in Earlham Hall on the campus 7:00 to 8:00 P.M., to permit the convenience of eating for those who will travel some distance.

Dr. Stanley will give a second address at 10:00 A.M., Saturday, September 20, in the Earlham College Field House. Subject: "Science as a Force for Peace." The public is invited on this occasion.

The medical profession joined with community leaders to give a rousing send-off to Dr. George E. Stauffer who began the practice of medicine at Mooreland, eleven miles northeast of New Castle, the second week in July.

The event was a dinner in Dr. Stauffer's honor, sponsored by the Lions Club at Mooreland, on June 30. Twenty physicians were present from Henry, Delaware, and Wayne counties, plus Dr. Carl H. McCaskey of Indianapolis, chairman of the executive committee of the Indiana State Medical Association, and Ray E. Smith of Indianapolis, the association's executive secretary.

Dr. McCaskey; Dr. W. U. Kennedy of New Castle, councilor of the Sixth district; Dr. Will Moore of Muncie; Dr. Charles Kime of Richmond, a classmate of the honor guest; and Dr. Stauffer were among those who spoke. Other physicians present were Drs. R. L. Amos, C. C. Canaday, B. L. Harrison, William Heilman, George Iterman, Homer Life, Robert A. Smith, Walter M. Stout, J. A. Tully, Walter Wright and D. S. Wiggins, all of New Castle; Dr. W. A. Miller of Hagerstown; Dr. L. C. Marshall of Mt. Summit; Dr. H. R. Shallenberger of Modoc; Dr. Jean F. Hinchman of Parker, and Drs. C. E. Rush and W. J. Molloy, both of Muncie.

Mooreland was left without a physician when Dr. W. E. Ticen died in January. Recognizing the need for medical services locally, the Lions Club appointed a committee to procure a physician. The committee rented a house so it would have a place for him to live, and offered assistance in buying and remodeling another house for offices. Dr. Stauffer, a native of Elkhart and graduate of the Indiana University School of Medicine, class of 1942, resigned from the Veterans' Administration to locate in Mooreland. He served for twenty-seven months in the Army, holding the rank of captain at time of discharge.

The fact that twenty-one physicians turned out on a hot night to honor Dr. Stauffer upon his entering private practice prompted Dr. Kennedy to remark: "This is the first time I've seen so many physicians gather to pay their respects to a new doctor. Usually we wait until it is the funeral of some doctor friend."

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INDIANA UNIVERSITY NEWS NOTES

Thirty-one physicians, recently appointed to house staffs of the Indiana University hospitals at the University Medical Center, began their internships on July first.

The new members of the house staffs of the Robert W. Long, William H. Coleman, James Whitcomb Riley hospitals and Rotary Convalescent home replaces a similar group which recently completed a year's training. Nineteen of the group are graduates of the Indiana University School of Medicine and the others hold M.D. degrees from medical schools in Nevada, Oklahoma, Texas, Kansas, Colorado, Maryland, Illinois, Missouri, Ohio and Wisconsin.

The appointments include, from Indiana: Dr. Arthur F. Aiken, Fort Wayne; Dr. Charles E. Buck and Dr. Robert H. Oswald, Jr., Evansville; Dr. Phyllis K. Catt, Rensselear; Dr. Warren E. Coggeshall, Saratoga; Dr. Jay W. Hammer, Jr., Middletown; Dr. John H. Houseworth, Elkhart; Dr. George T. Lukemeyer, Jasper; Dr. Edwin E. Pontius, Fort Wayne; Dr. John Richard Porter II, Lebanon; Dr. James S. Robertson, Plymouth; Dr. Robert W. Sappenfield, Bedford; and Dr. George C. Weinland, Hope; and Dr. David C. Gastineau, Dr. Oscar Green, Dr. Joseph B. Seagle, Dr. William S. Segar, and Dr. John R. Stanley, all of Indianapolis.

Coming from outside the state are: Dr. John O. Beatty, Reno, Nevada; Dr. Murlin K. Braly, Buffalo, Oklahoma; Dr. Ira E. Carroll, Trinity, Texas; Dr. Karl A. Ehrlich, Cold Water, Texas; Dr. George B. Kent, Jr., and Dr. Paul F. McCallin, Denver, Colorado; Dr. William Lovshin, Wisconsin; Dr. George C. Rasch, Jr., Baltimore, Maryland; Dr. George E. Stokes, Calumet City, Illinois; Dr. Rhey Walker, Hillsboro, Texas; Dr. James H. Wells, Springfield, Missouri; Dr. Douglas E. Wilson, Clinton, Oklahoma; and Dr. Jefferson C. Woodbury, Akron, Ohio.

Books

BOOKS RECEIVED

The Psychoanalytic Study of the Child, Volume II. 424 pages. Cloth. Price $7.50. International Universities Press, New York City, 1947.

The Rh Factor. By Edith L. Potter, M.D., Assistant Professor of Pathology, Department of Obstetrics and Gynecology, The University of Chicago and the Chicago Lying-in Hospital. 344 pages. Cloth. Price $5.50. The Year Book Publishers, Inc., Chicago, 1947.

Nutritional and Vitamin Therapy in General Practice. By Edgar S. Gordon, M.D., Associate Professor of Medicine, University of Wisconsin. 410 pages. Cloth. Price $5.00. The Year Book Publishers, Inc., Chicago, 1947.

Clinical Allergy. By Alexander Sterling, M.D., Diplomate in Internal Medicine, Fellow of the American Academy of Allergy. 198 pages. Cloth. Price $5.00. International Universities Press, New York City, 1947.

A Textbook of Medicine. By Russell L. Cecil, M.D., Professor of Clinical Medicine, Cornell University Medical College. With assistance of Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University Medical College. Associate Editor for Diseases of the Nervous System: Harold G. Wolff, M.D., Associate Professor of Neurology, Cornell University Medical College. Seventh Edition. 1,730 pages, with 244 illustrations. Cloth. Price $10.00. W. B. Saunders Company, Philadelphia, 1947.

Surgical Pathology. By William Boyd, M.D., Professor of Pathology, The University of Toronto, Canada. Sixth edition. 858 pages, with 530 illustrations, including 22 color figures. Cloth. Price $10.00. W. B. Saunders Company, Philadelphia, 1947.

Diseases of Metabolism—Detailed Methods of Diagnosis and Treatment—A Text for the Practitioner. By Garfield G. Duncan, M.D., Clinical Professor of Medicine, Jefferson Medical College, Philadelphia. 1,045 pages, with 167 figures. Cloth. Price $12.00. W. B. Saunders Company, Philadelphia, 1947.

Diseases of the Chest: With Emphasis on X-ray Diagnosis. By Eli H. Rugin, M.D., visiting physician in Tuberculosis and Physician-in-charge, Chest Clinic, Morrisania City Hospital, New York. 685 pages, with 355 illustrations (24 plates in color). Cloth. Price $12.00. W. B. Saunders Company, Philadelphia, 1947.

Gynecology with a Section on Female Urology (Second Edition). By Lawrence R. Wharton, M.D., Assistant Professor of Gynecology, The Johns Hopkins Medical School. 1,027 pages, with 479 illustrations. Cloth. Price $10.00. W. B. Saunders Company, Philadelphia, 1947.

REVIEWED

ARTERIAL HYPERTENSION, Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D., of the Research Division of the Cleveland Clinic Foundation, Cleveland; formerly with the Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis. 352 pages with 14 illustrations. Price, $3.75. Cloth. The Year Book Publishers, Incorporated, Chicago, 1945.

Here is a useful, compact book for the general practitioner, with a wealth of information and no padding. Particular interest is attracted to the description of the patient as a body with personality and not just a case of high blood pressure. It contains some profound philosophy on the evaluation of the background of the patient's disability. This is a welcome relief from a mass of scientific data. The chapters on treatment include the discriminating use of Thiocyanate, with little enthusiasm for kidney extract and none for Vitamin A. However the indications for the surgical approach are evaluated very judiciously.

Charles N. Combs.

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Deaths

Robert E. Trout, M.D., of Oaktown, died at his home on June nineteenth. He was ninety-one years of age. Doctor Trout had been retired from practice for approximately fifteen years.

* * *

Grant Vern Newcomer, M.D., of Elwood, died on July ninth at the age of eighty. He was a graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1891.

* * *

Alexander Hamilton, M.D., of Frankfort, died on March second, at Melbourne, Florida. He was seventy-two years of age. Doctor Hamilton was a graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1904, and was a member of the Clinton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Mary Wickens, M.D., of Richmond, died on July second at the age of seventy-three. A graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906, she had served for many years on the staff of the Richmond State Hospital. Doctor Wickens was a member of the Wayne-Union County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Sherman L. McKinney, M.D., of Huntingburg, died on May twenty-ninth. He was fifty-nine years of age, and had practiced medicine in Huntingburg for thirty-three years. He graduated from the University of Louisville School of Medicine with the class of 1912. Doctor McKinney was a member of the DuBois County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

George B. Morris, M.D., Bluffton, died on June seventeenth at the age of sixty-seven. At the time of his death Doctor Morris was serving as city health officer. He was a graduate of the Indiana Medical College of Medicine of Purdue University, Indianapolis, in 1906, and had practiced in Wells County for forty years. Doctor Morris was a veteran of World War I. He was a member of the Wells County Medical Society, the Indiana State Medical Association, and the American Medical Association.

John E. Derbyshire, M.D., of Van Buren, died on June twenty-first after an illness of two years. He was seventy-three years of age. Doctor Derbyshire graduated in 1903 from Rush Medical College, and had practiced in Van Buren for forty years. He was a member of the Grant County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Harry E. Gabe, M.D., of Indianapolis, died June fourteenth at the age of seventy-nine. After graduating from the Medical College of Cincinnati in 1893 he began private practice in Indianapolis. He was a past president of the Indianapolis Medical Society, and had been vice-president of the city Board of Health. Doctor Gabe was an honorary member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

R. G. E. Haymond, M.D., of Waldron, died June twentieth at the age of sixty-nine. He was a graduate of the University of Louisville School of Medicine in 1909. Doctor Haymond retired several years ago.

* * *

Abraham J. King, M.D., of Indianapolis, died on June seventeenth at his home. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1907, and had practiced in Indianapolis since that time until his retirement in recent years. He was eighty-four years of age.

* * *

Napoleon LaBonte, M.D., of Monrovia, died on June twenty-sixth at the age of sixty-four. He graduated from the Indiana University School of Medicine, in 1920, and had practiced in Indianapolis for twenty-five years. He retired six months ago. Doctor LaBonte was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Donald E. MacGregor, M.D., of Indianapolis, died on June twentieth at the age of fifty-five. He was a graduate of the Chicago College of Medicine and Surgery in 1917, afterwards serving as a surgeon with the Army of Occupation in Germany in World War I. Doctor MacGregor was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

May 23, 1947

Present: H. G. Hamer, M.D., chairman; David L. Smith, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health" columns for weekly newspapers were approved:

Week of July 7, 1947—"Losing Weight."

Week of July 14, 1947—"Tests of Allergy."

Week of July 21, 1947—"Paralysis Agitans."

Week of July 28, 1947—"Heat Exhaustion."

A booklet of speakers and their subjects issued by the Illinois State Medical Society was discussed and decision made to the effect that similar data be collected in Indiana.

The secretary reported that a list of physicians who had delivered essays at district and county medical meetings was supplied the program chairman of the Second District Medical Society.

COUNCILOR DISTRICT MEETING

EIGHTH DISTRICT

Dr. Frederick B. Wishard of Anderson was elected president of the Eighth District Medical Society at the 1947 meeting held in Portland on June 25. Dr. M. A. Austin, also of Anderson, was elected secretary-treasurer. Anderson was chosen for the 1948 meeting.

Speakers at the meeting were Dr. Floyd T. Romberger of Lafayette, president of the Indiana State Medical Association; Dr. E. H. Clauser of Muncie, councilor; Ray E. Smith of Indianapolis, executive secretary of the state association, and Dr. Frank W. Teague of Indianapolis, who gave an illustrated lecture on "Low Back Pain."

Golf prizes were awarded to Dr. Wonderly of Muncie, Dr. Charles T. Botkin of Muncie, and Dr. I. E. Brenner of Winchester.

Dr. Forrest E. Keeling of Portland, district president, presided. He presented the question of holding postgraduate courses, and the physicians voted in favor of holding them at some centrally-located city in the district.

LOCAL SOCIETY REPORTS

Fountain-Warren County Medical Society members entertained the Tippecanoe, Montgomery, and Danville (Illinois) County Medical Societies at their traditional Wabash Valley catfish fry held on June twelfth at Covington. The guest speaker was Mr. Oscar M. Helmer, a physiologist from the research department of Eli Lilly & Company who discussed hypertension. Approximately fifty-three members and guests were present.

* * *

Kosciusko County Medical Society members held a meeting on June eighteenth, as guests of Dr. T. S. Schuldt, of Pierceton, at his cottage on Ridinger Lake. Fourteen members and two guests attended the meeting. Dr. Arnold H. Duemling of Fort Wayne, discussed pyloric stenosis in infants, and Dr. W. F. Gessler of Fort Wayne, talked briefly on vaso-motor rhinitis.

* * *

Morgan County Medical Society members met at the Morgan County Memorial Hospital on June eighteenth. The eight members present heard Dr. K. L. Dickens, of Martinsville, speak on "The Veterans Administration as it Relates to the General Practitioner."

* * *

Perry County Medical Society members met on June twenty-fourth at the county nursing center, in Cannelton. Dr. N. A. James, of Tell City, presented a paper on the indication and treatment of penicillin. All members attended the meeting.

* * *

Putnam County Medical Society members were guests of Miss Gladys Brandt, superintendent, and the Board of Trustees of the Putnam County Hospital at a dinner meeting on June twelfth.

* * *

Whitley County Medical Society members held a meeting at the "30" Club, in Columbia City, on June tenth. The speaker for this meeting was Dr. Maurice Glock, of Fort Wayne, whose subject was "Jaundice." Nine members attended the meeting.



The First Prescription...

The First Prescription was written in Egypt about 3700 B.C. Later, when the color of an herb was believed to indicate which planet it was under and for what disease it should be used, herbs were compounded with long prayers for their success to Jupiter, largest of the planets. Next, the prayers were condensed, written over the command "Recipe!" (Take!), and finally shortened to ℞ (R plus a vestige of the old sign of Jupiter).

The First Dental Prescription was Galen's, about 165 A.D.—a smooth paste for the cavity of an aching tooth (carrot, anise and parsley seeds, saffron, black pepper and opium).

Between those prescriptions—about 2030 B.C., in the Code of Hammurabi—broke the dawn of malpractice law. ("*If the doctor has caused a gentleman to die, one shall cut off his hands . . . if he has caused a slave's death, he shall render slave for slave.*")

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OUR GOAL

"Every Doctor's Wife an Auxiliary Member"

President's Letter:

Hm! August again and time for yearly programs to be planned. We promised to have suggestions available for you. Mrs. Lybrook, our program chairman, has already mailed these to president's of county auxiliaries, but we felt others of you would be interested. We know that somewhere over the state are other wonderful ideas for programs. Send them to us and we can add to these suggestions later on in the year. We'd like constructive criticism on these, too. Whether you are an officer, committee chairman, or just a member, form the habit of writing to us. Help us make Indiana the most progressive state auxiliary of all.

SEND US A COPY OF YOUR PROGRAM WHEN COMPLETED. We'd like to reach the point (OH HAPPY DAY) where we could publish **advance notices** of county meetings. It might be possible then for doctor's wives from adjoining counties who want to associate with an auxiliary to attend meetings, instead of reading about them two months later and thinking, "I'd have gone, had I known about it."

DO YOU HAVE YOUR RESERVATION FOR CONVENTION? Big things are being planned. The three day meeting is going to give us a chance to do more things together and become better acquainted.

Rebecca Ratcliffe, President.

Suggested Programs for WOMAN'S AUXILIARY—1947-48

* * *

Suggestion Number One

Subject: "Mutual Medical Insurance, Inc., Indiana's Prepayment Medical Plan."

Suggestion Number Two

Subject: "Indiana's Public Health Program."

Suggestion Number Three

Subject: An "Information Please" program on local health.

Suggestion Number Four

Subject: "Mental Health in Indiana."

Suggestion Number Five

Subject: "Community Health Day"—including health and social hygiene talks.

Suggestion Number Six

Subject: "Sanitation in Food-Handling Establishments."

Suggestion Number Seven

Subject: "Status of the Wagner-Murray-Dingell and Taft Bills."

Suggestion Number Eight

Subject: "Distribution of Health Information at Local Fair."

Suggestion Number Nine

Subject: "A Visit to the State Legislature."

Suggestion Number Ten

Subject: "Powder Room Chats."

Suggestion Number Eleven

Subject: "Recruiting for Student Nurses."

HIVES SUFFERERS GAIN RELIEF FROM ITCHING WITH BENADRYL

Benadryl is highly effective in the treatment of certain diseases of the skin such as hives, according to two Rochester, Minnesota, physicians.

Writing in the July 19 issue of *The Journal of the American Medical Association,* the physicians—Paul A. O'Leary and Eugene M. Faber from the section on dermatology and syphilology, Mayo Clinic—prescribed Benadryl to be taken by mouth every three to four hours for 35 patients who had acute hives. Twenty of the patients were completely relieved in from one to two days; the condition of 12 was improved and three patients were not benefited

The authors state that when Benadryl is administered, relief from the intense itching usually occurs in 20 to 60 minutes, with reduction of the swelling in from two to six hours. However, relief is obtained only while the drug is being used.

Another group of 75 patients with chronic hives, which may last for many years, were treated with the drug with the following results: 48 were entirely relieved while they were taking Benadryl, 17 were partially relieved and 10 obtained no benefit.

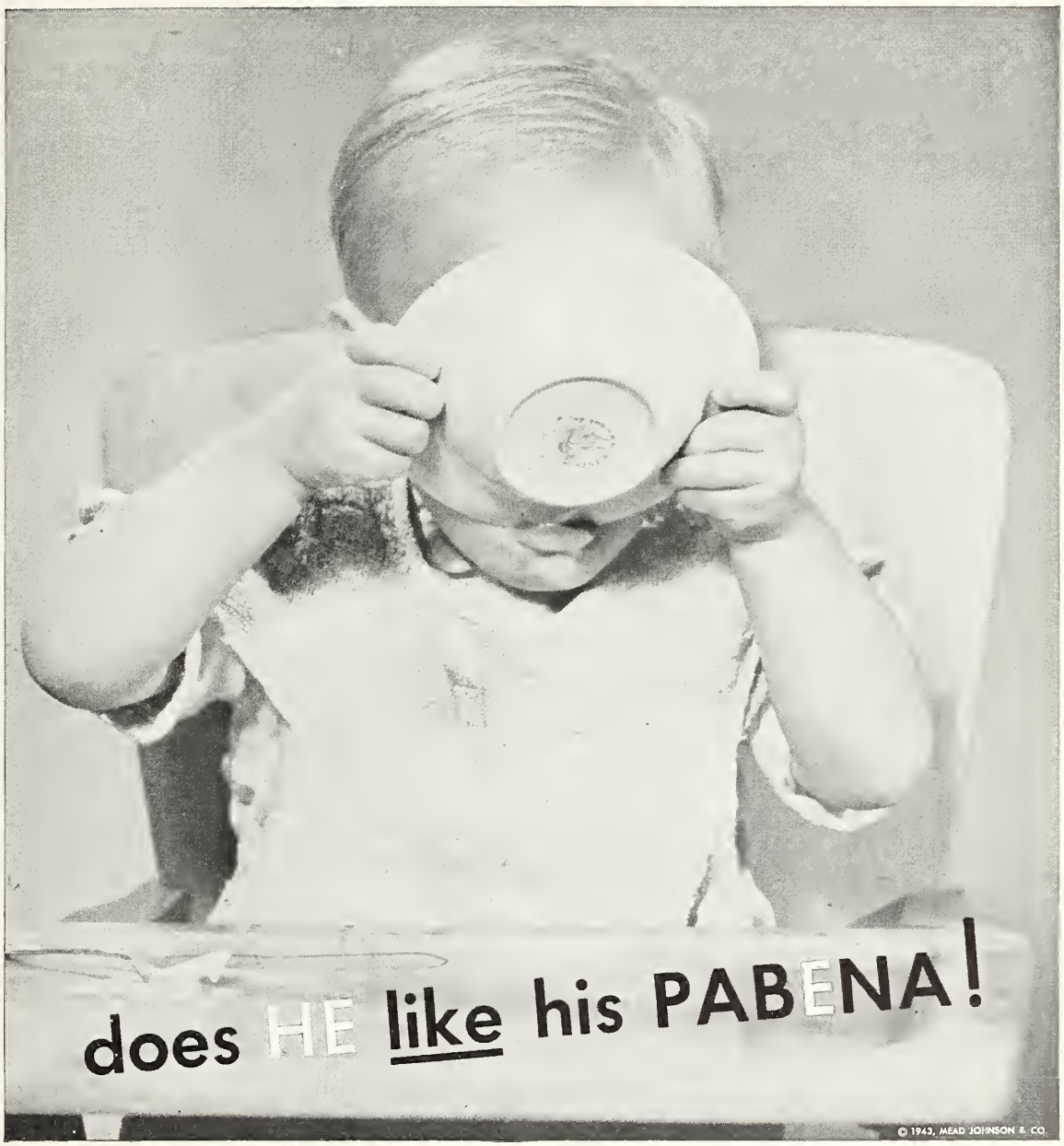
There have been a great number and variety of treatments tried but no single one has been of consistent benefit to patients who have hives chronically. The physicians therefore feel that Benadryl has given striking relief to most of these patients who may be wholly or partially incapacitated because of intense itching, insomnia and disfigurement.

Another 76 patients with miscellaneous skin diseases were treated with Benadryl but few experienced the relief of the hives sufferers.

"Side reactions occurred among 31 per cent of the patients in this study," according to the physicians, "but were severe enough to warrant discontinuance of the administration of Benadryl to only 10 patients."

The side reactions in order of frequency were drowsiness, dizziness, weakness and dryness of the mouth. Some patients complained of being "jittery," "on edge," "nervous," "confused," "poorly coordinated," "nauseated" and "excited."

"Side reactions usually occur during the first few days after the administration of the drug is begun and frequently diminish in severity or disappear entirely after several weeks of treatment," state the authors.



WHEN interviewed between platefuls, this 11-months-old young man emphatically stated: "I have been brought up on Pablum and still like it, but some days when I'm in the mood for oatmeal, nothing satisfies me like Pabena!"

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INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—May, 1947

Diseases	May 1947	Apr. 1947	Mar. 1947	May 1946	May 1945
Brucellosis	11	5	10	8	3
Chickenpox	268	541	506	298	219
Diphtheria	13	32	52	36	17
Dysentery (Bacillary)	2	...	..	1	2
Encephalitis	2	1	10	1	...
Epilepsy	1	...	..	...	...
Impetigo	5	5	2	6	2
Influenza	7	68	1250	21	26
Malaria	6	4	5	20	1
Measles	478	504	244	1957	157
Meningitis (Cerebro-Spinal)	3	12	4	10	12
Meningitis (Meningococcus)	9	4	3	...	...
Meningitis (Pneumococcus)	1	...	...	...	...
Mumps	97	276	248	182	237
Pertussis	171	256	127	70	72
Pneumonia	28	80	93	22	9
Poliomyelitis	2	...	...	...	4
Rocky Mountain Spotted Fever	3	...	...	...	...
Rubella	6	9	1	28	8
Scarlet Fever	251	437	544	231	403
Septic Sore Throat	20	25	24	23	1
Smallpox	4	8	6	14	10
Tinea Capitis	13	31	22	...	...
Tularemia	1	1	4	1	...
Typhiod Fever	1	12	9	4	3
Vincent's Angina	2	...	...	4	2
Tuberculosis (Pulmonary)	220	295	222	...	...
Tuberculosis (Other Forms)	12	11	8	...	...

MONTHLY REPORT—JUNE—1947

Diseases	Jun. 1947	May 1947	Apr. 1947	Jun. 1946	Jun. 1945
Brucellosis	12	11	5	27	4
Chickenpox	122	268	541	263	162
Diphtheria	12	13	32	21	24
Dysentery (Bacillary)	2	2	---	---	---
Dysentery (Unclassified)	4	---	---	---	---
Glanders	1	---	---	---	---
Impetigo	5	5	5	3	5
Influenza	8	7	68	3	23
Malaria	1	6	4	18	3
Measles	230	478	504	1012	145
Meningitis (Cerebro-Spinal)	5	3	12	6	7
Meningitis (Meningococcic)	1	9	4	---	---
Meningococcemia	1	---	---	---	---
Meningitis (Influenzal)	1	---	---	---	---
Mumps	52	97	276	98	186
Para-typhoid Fever	1	---	---	---	---
Pertussis	153	171	256	172	103
Pneumonia	9	28	80	17	6
Poliomyelitis	1	2	---	9	7
Rocky Mt. Spotted Fever	10	3	---	1	6
Rubella	3	6	9	24	6
Scartlet Fever	93	251	437	165	219
Septic Sore Throat	20	20	25	22	1
Smallpox	1	4	8	6	1
Tetanus	1	---	---	2	---
Tinea Capitis	29	13	31	4	---
Tularemia	1	1	1	2	1
Typhoid Fever	4	1	12	6	10
Vincent's Angina	1	2	---	1	---
Tuberculosis (Pulmonary)	197	220	295	243	285
Tuberculosis (Other Forms)	14	12	11	24	12

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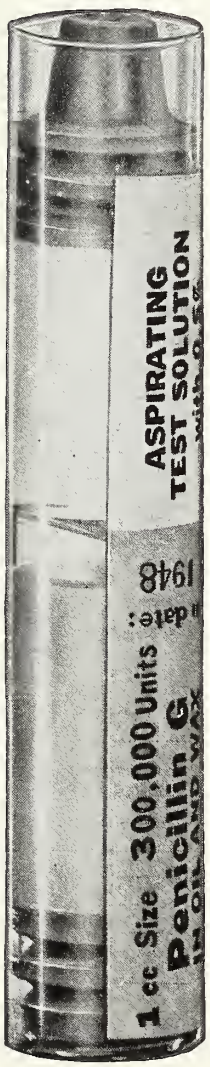
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ANEMIA AND CARDIAC CIRRHOSIS FROM RHEUMATIC HEART DISEASE

JACK L. EISAMAN, M.D.*

BLUFFTON

THIS is a subject which deserves more study than a survey of the literature reveals. A request for a bibliography on this topic sent to one of the leading firms carrying on this type of research was devoid of any papers. This certainly makes this type of report more valuable. It is the purpose of this paper to bring to the attention of the general practitioner the heart and, secondarily, the liver, as possible etiological factors in anemia. For too long iron, or liver and iron, have been given the patient without any thought as to the type or etiological background of the disease. This practice, of course, is not justifiable. With a hemoglobin determination, red blood cell count, and hematocrit determination one can classify the anemia as to whether it is macrocytic, microcytic, or normocytic, or whether it is hyperchromic, hypochromic, or normochromic, and then correctly give liver or iron.

The pathogenesis of the anemia is the next point. Because of the proximity of the hepatic veins to the point where the inferior vena cava empties into the right auricle, any back pressure is first felt in the liver and portal system. The most common cause of this is valvular heart disease, particularly mitral stenosis and myocardial failure. Obstruction to the pulmonary circulation, such as chronic interstitial disease processes, emphysema, or tumors will produce the same result.

The microscopical picture of the liver is one of extreme congestion of the central vein and center of the lobule. The sinusoids next to the central vein are dilated and the liver cells are degenerated and atrophied. The cells are replaced by fibrous tissue, and thus comes the term cardiac cirrhosis. This replacement fibrosis may convert a liver that was originally enlarged to one that is diminished in size. This atrophy is thought to be due to anoxemia from chronic stasis rather than pressure necrosis.[1]

The gross appearance in its early stages is an enlarged, firm liver with a tightly stretched capsule. On section, the lobular markings are definitely prominent. The center of the lobule is red from congestion, and the periphery is pale from degenerative and fatty changes that occur as a result of a stagnant circulation. This is pathologically described as the "nutmeg liver."

The stomach and other organs in the portal circulation are involved in the venous backpressure. This serves to cause gastro-intestinal dysfunction and complaints which have the heart as their background.

The spleen is the other organ in this study which is of particular importance as far as an anemia is concerned. Since it occupies an upstream position with reference to the liver, it will show the effects of any portal obstruction. The enlargement in mitral disease is not usually associated with a spleen as large as in portal cirrhosis, but in some of the case reports which follow it has been detected clinically. In one case it was felt advisable to remove the spleen because of its adverse effect in maintaining a normal red blood count. In the early stages it may be only slightly enlarged but later it may weigh over 300 Gm. Early, its cut surface will bulge and bleed, but later it becomes firm and neither bulges nor bleeds. The capsule and trabeculae are thickened. Microscopically, the sinuses

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1. Boyd, William: Pathology of Internal Diseases; Third Edition; pp. 342; Philadelphia, Lea & Febiger; 1940.

are congested and distended. There is atrophy of the lymphoid tissue. The capsule and trabeculae may become extremely thickened and the spleen very hard and firm. Later on the spleen may decrease in size as a result of shrinking of the fibrous tissue or improvement of cardiovascular dynamics.

It is our opinion that the liver-spleen dysfunction, resulting from portal stasis, is the background of the associateed anemia in the following cases.

Case I

W.R.C., a 55-year-old, married, white male was first seen on October 10, 1942. His occupation, family, and marital history are noninforming. His important past medical history includes rheumatic fever at the age of 16, typhoid fever at age 10, gonorrhea at age 30, influenza at age 26 (1918), appendectomy at age 43, and pneumonia at age 54. The patient knew he had heart trouble. He complained of dyspnea, swollen ankles, and weakness. He had had his rheumatic heart disease since age 16, but it had not disturbed him until three months previously when he noticed a shortness of breath with exertion. This had become progressively worse, associated with a disturbing cough. For a month he had swollen ankles which would swell through the day and disappear by morning. He had not been able to eat well for a long time because of anorexia. The positive physical findings were a mild cardiac enlargement to the right and left with mitral systolic and diastolic murmurs and an aortic systolic murmur. The liver was enlarged and there was some pretibial edema.

The chest film showed the cardiac silhouette enlarged to the right and left, having a diameter of 13.5 cm., compared to a chest diameter of 25.5 cm. The height was 67 inches, the weight 102 pounds, thus making the heart 29 per cent above average normal size. There was prominence of the pulmonary conus and a mitral configuration. The lung fields did not suggest any congestion.

The electrocardiogram revealed an AV rate of 98, PR interval .16 seconds, QRS .16 seconds. There was ST depression in leads 1 and 2, and T 4 R was diphasic. The angle of the electrical axis was + 42°. R 1 was slurred and R 3 notched.

Pyelograms revealed a mild, right-sided pyelonephritis.

The original blood counts were hemoglobin 64 per cent (photolometer), red blood counts 3.73, white blood count 5,200 with a reversed differential. The icteric index was 6, the gastric analysis and basal metabolic rate were normal. The abnormal findings in the urine were a trace of albumin and 2 + pus cells.

His first hospital stay was 90 days. It was most difficult to maintain a normal hemoglobin. He had a total of 10 whole blood transfusions consisting of 500 cc. each. The lowest level that his hemoglobin reached was 52 per cent and the highest was 80 per cent. This elevation was short lived; it stayed around 55 to 65 per cent. Associated with this he had an intermittent low grade fever which would occasionally shoot to 102°. Because of a chronic prostatitis which had produced a bladder neck contraction and urinary obstruction with pyuria, a transurethral resection was done. This was not done until the G. I. tract, including the gall bladder, was ruled out as a possible site for blood loss. Also, several blood cultures were negative. Stools and urines were negative for blood. Even forty days postoperatively (his ninetieth post-admission day), when his temperature was running close to normal, his hemoglobin was only 55 per cent. At first he was digitalized and cardiac compensation resulted. He went through prostatic surgery very well. He was feeling fairly well, and because of having been hospitalized for so long, the patient was sent home on January 6, 1943. One week later the patient was readmitted. On the way home he had developed a cold and purpuric spots came out on his legs. These became worse the night before admission. He was very pale and thin. Temperature was 101°. The heart sounds were about the same. The abdomen was bloated. The liver was much the same size but the spleen became so large that it was palpable 12 cm. below the left costal margin. There were purpuric spots over both legs. The clinical impression was splenic anemia. Hemoglobin was 49 per cent (7.3 Gm.) red blood cells 3.24 and hematocrit 26 per cent. The mean corpuscular volume was 80 and the mean corpuscular hemoglobin 22—a normocytic, hypochromic anemia. The platelet count was 162,500. Between January 15, 1943, and death on February 25, 1943, the patient received 15 whole blood transfusions of 500 cc. each. The highest hemoglobin determination was 68 per cent and the usual figure was in the lower fifties. On January 19, 1943, after a transfusion, the patient experienced severe chest pain, dyspnea, and with this fine crackling rales were heard over the chest. A chest film the next day revealed the heart size to have increased definitely since the previous October. He continued to have an intermittent type of fever, but repeated blood cultures were negative and the heart sounds did not change. The spleen remained large; the blood could not be maintained. Knowing he could not survive the way he was going, he was put in the best possible shape for surgery (hemoglobin 68 per cent and no evidence of pulmonary congestion), and splenectomy was done on February 24, 1943. After surgery he did not rouse; the pulse became more irregular and thready. He developed pulmonary congestion, became worse, and died.

Case II

This is the case of a 63-year-old, married male who complained of swelling and blistering of his legs, nocturia, and nausea. Positive facts in the family history were the father, who died of cancer

of the mouth, and a brother, who died from an operation on the spleen. During his life he had the usual childhood diseases, influenza, attacks of tonsillitis, and rheumatism.

The present illness started about nine months previous to admission, when he first noticed some swelling of his ankles. He became progressively worse until his legs, waist, and hands were involved. Recently he had been coughing. Blisters had come on his legs three weeks prior to admission, and after they broke open serum oozed from them. For the past two years the patient had had to get up at night to void one to six times. He had no trouble passing urine and he passed a large volume. He had noticed that slight exertion made him short of breath and he had to stop, "to get my breath."

Physical examination revealed a thin, linear built man, 72 inches tall, and weighing 150 pounds. The blood pressure was 150/90, pulse 76, and temperature 98. The positive findings were the heart and general edema. There was a reduplication and slurring of the first heart sound with a long, soft, rumbling diastolic mitral murmur.

The chest film revealed a long, narrow chest with a small, vertical heart measuring 11.0 cm. This was 10 per cent less than average normal size predicated according to his height and weight. There was a small amount of pleural effusion at both bases. There was no evidence of pericardial calcification. Fluoroscopy with gastro-intestinal series, cholecystograms, and intravenous pyelograms were normal. Cystoscopy revealed a moderate hypertrophy of the median lobe of the prostate with only a very low grade obstruction.

His electrocardiogram was not remarkable, indicating only a sinus tachycardia with an occasional ventricular premature contraction.

His first complete blood count was not remarkable. His first urine specimen had a specific gravity of 1.025 and was completely negative. The sedimentation rate was 90. The total protein was 4 with globulin 2.32 and albumin 1.68 with a ratio .72/1.

A glucose tolerance test produced a normal curve. However, the fasting specimen was 71 and the three hour specimen 74. The blood urea nitrogen was 14. Bromsulfalein dye excretion test was normal. A culture of the urine in dextrose brain broth media produced no growth.

It was felt the mitral stenosis had produced a chronic cirrhotic liver, and that the two together were operating here to produce this edema. Bed rest and digitalization were ordered for the patient until he could return for admittance to the hospital.

Three weeks later, upon admission to the hospital, he stated he felt improved but his appetite was not much better. His weight had dropped from 150 to 137. His hemoglobin was down to 62 per cent and red blood count 3.39; the hematocrit was 40 per cent, making a mean corpuscular volume 120. The plasma protein was still low. His urine was loaded with albumin but had only an occasional pus cell and no casts. Because of his low plasma protein and cellular elements whole blood transfusions were given. The blood was easily raised to normal in hemoglobin and red blood count but the total protein was only brought to 5.2.

The patient was sent home on a high calorie, high protein, high carbohydrate, low fat, low salt diet, digitalis, and liver extract, 1 cc. parenterally, daily. He was not seen again for a month. At that time his hemoglobin was 77 per cent (12.1 gm.), and red blood count 4.12, hematocrit 41, making the mean corpuscular volume 99 and the mean corpuscular hemoglobin 29. The urea was 32, total protein 4.4 with AG ratio .41/1. The Mazzini was always negative. He still had some pretibial edema; liver dullness was three fingers below costal margin. Weight was 150½ pounds. Because of his inability to maintain normal plasma protein he was unable to remain free of edema.

Information by correspondence from the patient's family indicated that the patient became gradually worse. He became very dyspneic and died three months after his original examination.

Case III

This is the case of D.S., a 59-year-old, white woman, who registered on June 20, 1946. Her chief complaints were shortness of breath, loss of 75 pounds in weight, and vomiting spells. The mother died at 83 with heart trouble. The father died at 60 with Bright's disease. One sister died of heart trouble. Patient had been married for 39 years and had six children, living and well. Her past history indicated tonsillitis in childhood, and rheumatism of the neck, shoulders, and fingers. She had had some "asthma" for the past few years.

She had had a very bad cough before a severe attack of dyspnea 2 years previously. She was hospitalized for three months and was home in bed for three months. With this she had a dull misery in the epigastrium, associated with vomiting spells, and a couple of weeks of freedom between attacks. She was finally able to be up and around and was fairly well for six months. Then she began having dyspnea, epigastric distress, and vomiting. She returned to the hospital and stayed for seven months. She only gradually improved so as to be up and around. It was at this time that she entered the Clinic Hospital. She had had a chronic cough for years. She had pretibial edema when her feet hung over the bed. She would have to get up four times at night to urinate. She had never had any anginal pain.

The positive findings of the physical examination revealed a well developed but poorly nourished female, not acutely ill. Blood pressure varied around 200 systolic and 100 diastolic, pulse 89, with an irregular irregularity. There was an irregular nodule the size of a small egg in mid-

thyroid region. There were fine crepetant rales heard over the right lower lobe. The heart revealed a medium, short, blowing systolic murmur followed by a harsh, slightly rumbling, long diastolic mitral murmur. The retinal vessels showed some tortuosity and sclerosis associated with a few areas of hemorrhage. The liver was palpable three fingers below the costal margin, and quite tender. The tip of the spleen was palpable and tender. There was no demonstrable pretibial edema.

The chest film showed a cardiac shadow of 12.5 cm. The height was 61 inches and weight 105. According to the predication table the heart was 12 per cent above average normal size. There was prominence of the right ventricle and outflow tract, as well as of the pulmonary artery and bronchovascular markings suggesting congestion.

The electrocardiogram indicated a complete AV dissociation with a ventricular rate of 90. ST 1 and 2 were depressed with some effect on T waves. The angle of electrical axis was plus 46°.

Cholecystograms revealed a nonfunctioning gall bladder, but it was felt that this might be due to poor liver function. A gastro-intestinal series was negative. Films with a barium enema were negative except for showing extensive calcification of the pelvic arteries. Films of the thoracic spine revealed large hypertrophic spurs. Dental x-rays revealed two root tips, which were removed. Intravenous pyelograms revealed fair dye excretion but mild contraction of the right kidney.

The basal metabolism was within normal limits.

The urine contained two plus albumin with a specific gravity 1,026, 1 + sugar, and a few pus cells. The blood sugar was 330, urea 36, cholesterol 222, total proteins 6.2. The bromsulfalein liver function test indicated no abnormal dye retention.

The hemoglobin was generally in the low seventies. At one time it was as low as 64 per cent with a 3.55 red blood count. This made the mean corpuscular hemoglobin 28. Because of the leakage of blood in the retina and what was considered an insufficient arteriosclerotic hypertensive background, a platelet count was done. This was 67,680 and later went to 86,450. Also a positive Rumpel-Leede test existed. So the retinal leakage was explained upon a thrombocytopenic diapedesis.

The patient was put on diabetic management, rest, continued use of digitalis, iron, and vitamin B complex. She improved and went home. When we heard from her, six weeks later, she was doing fairly well. However, it was not long after this that we received word of her death.

This case presented multiple problems and diagnoses. She had a mitral stenosis which caused chronic passive congestion in the liver. One may speculate about the association of this and her diabetes. Also, the nonfunctioning gall bladder raised a problem as to whether it was due to gall bladder or liver disease. Regardless of these associated factors, it is felt that the heart and its secondary effect on the liver and spleen were responsible for the anemia.

It is felt that the valvular heart disease produced a very long standing, chronic, passive congestion in the liver with a cardiac cirrhosis. This exerted back pressure on the spleen with splenomegaly. The liver-spleen dysfunction was held accountable for the severe anemia and finally resulted in a thrombocytopenic purpura.

Case IV

Mrs. M.T., a 37-year-old white woman, was first seen in the Clinic on October 17, 1943. There was no past history of rheumatic fever. A tonsillectomy was done at age 15. Three years prior to admission she had pneumonia and pleurisy and never fully recovered. She was in the hospital twelve days and up and about in three weeks. Swelling in her abdomen started two years later (one year ago). Recently she had swelling of the feet and legs, she couldn't lie down to sleep, coughed a lot, and noted dyspnea after eating. Her appetite was poor and she suffered nocturia several times.

Her blood pressure was 110/70, pulse 110. The tongue was red and the teeth very poor, with poor oral hygiene. There were no murmurs detected by the examining clinician. There was evident lagging of the right lower chest with inspiratory and expiratory rales. Marked edema was present in the lower abdomen and legs.

The important laboratory findings were a hemoglobin of 71 per cent, red blood count 3.59, and normal white blood count. Fluid from the abdomen was negative for cells of malignancy, and smears and culture were negative for acid fast bacilli.

A chest film revealed a cardiac shadow which was within normal limits in its transverse diameter. The right ventricle was prominent and there was flattening of the left auricular salient. There was definite congestion of both lower lobes.

Electrocardiogram indicated an AV rate of 130, PR interval .12 seconds, QRS interval of .05 seconds. R 1 and S 3 predominated, making the angle of electrical axis 0°. There was slight depression of ST 2 and STCR 4, with slight effect on the T waves.

A full mouth dental x-ray revealed several abscesses and marked pyorrhea. She was digitalized and had a fair response, but did not continue to respond and was hospitalized on January 4, 1944. Again she was very edematous, dyspneic, and most uncomfortable. She had had a tooth extracted at home and was greatly upset by it. This had aggravated some joint pains she had been having. At this time a diastolic mitral murmur was detected when the patient was placed on her left side. This explained the patient's cardiac failure, which was more symptomatic as a right-sided than a left-sided affair.

Her hemoglobin this time was 52 per cent (8.2 Gm.) and red blood count 2.77, prothrombin time

90 per cent, icterus index 8, blood urea nitrogen 5, serum chloride 514, total protein 4.44 Gm., specific gravity 1,020 (serum), normal bromsulfalein dye excretion, decreased fragility of red blood cells in saline, and platelet count 413,000.

The pathogenesis seemed clear now. She had had leg ache all the time as a child. This was increased by her tonsillectomy. Study of her chest film revealed mitral configuration and pulmonary congestion. Finally, with patient on left side one could detect a sharp systolic slap and a diastolic rumble over the mitral area. The break in health, three years prior to admission, which was called pneumonia, was probably her first severe myocardial failure. She was ill for twelve weeks and never strong thereafter. About a year ago she had to sit in a chair and gasp for breath, and had swelling of her legs, with weeping of fluid from both shins. Hemoglobin in October was 71 per cent, five months later it was 52 per cent. Examination of pelvis after abdominal paracentesis was negative, but the liver was four inches below costal margin, and tender. Her mitral stenosis and long standing, chronic passive congestion resulted in cardiac cirrhosis and secondary anemia. The spleen was not palpable. The patient wanted to go home without further treatment. She signed her own release and has not been seen since.

Case V

This is a 65-year-old, white widow, whose chief complaints upon admission were weight in the stomach and liver, soreness, gas and belching, and a drawing sensation under right shoulder blade. Her family history was negative except for a sister who died of diabetes. A cholecystectomy and appendectomy were done nine years ago. Seven years ago a breast was removed because of a nonmaligant tumor. The tonsils were removed at an early age.

For a long time the patient had used Fleets Phospho-soda for the above complaints and obtained relief in a few days. However, the past six weeks had been miserable and without relief. She suffered some dyspnea with the gas. There was no pain with exertion nor edema. Physical examination revealed a well developed and well nourished lady, 62 inches tall, and weighing 125 pounds. The blood pressure was 130/80, pulse 110, and temperature 98.4°. The main physical findings were the heart and liver. There was a short but loud systolic murmur followed by a loud, long, harsh diastolic mitral murmur. The liver was palpable and tender.

The chest film revealed moderate arteriosclerosis of the aorta. The cardiothoracic ratio was 13.5 cm. to 26.8 cm., the cardiac contour suggested slight enlargement of the generalized type, and there was flattening of the left upper cardiac border. The lung fields were clear. According to the patient's weight and height the heart was 13 per cent above average normal size. At fluoroscopy the esophagus was moderately displaced by the left auricle.

The electrocardiogram indicated the greatest QRS voltage to be .7 MV and slight slurring in all leads. The T waves were low voltage in the standard leads.

The hemoglobin was 9.9 Gm., or 64 per cent, and red blood count 3.51, white blood count 5,100, with 30 per cent neutrophils and 70 per cent lymphocytes. A later check revealed 9.9 Gm., or 64 per cent, 3.58 red blood cells, and white blood count 5,400, with 24 per cent neutrophils and 76 per cent lymphocytes. The lymphocytes were of normal size and no pathological forms were seen. The hematocrit was 34 per cent. This resulted in a mean corpuscular volume of 95 and a mean corpuscular hemoglobin of 25—a normocytic, hypochromic anemia. An icterus index was 8, a platelet count 84,240, and a blood sugar 87. A gastric analysis, urinalysis, gastro-intestinal series, and barium enema were not remarkable.

It was felt that her heart was the cause of her liver congestion and discomfort, and the background of her associated anemia.

Case VI

Mrs. G.W. was first seen in the clinic on July 26, 1940. At that time she was only 33 years old, married, and had one child, living and well. The father died at age 64 with kidney stones and heart disease, and one of her siblings died of heart trouble. Patient claims her heart disease started after having diphtheria, but she also had rheumatism and tonsillitis as a child. She had a tonsillectomy, adenoidectomy, and a mastoidectomy in 1922.

Her complaints upon admission were shortness of breath upon exertion, swelling of abdomen, seepage from navel, swelling and discoloration of legs, and leakage of the heart.

Physical examination revealed a fairly well developed and nourished female, not acutely ill. The main physical findings were the heart and the effects of a right ventricular failure. The heart was enlarged to the right and left. A diastolic thrill was detected at apex and a systolic thrill at base. At the apex a medium, long, crescendo systolic, and medium, long, rumbling diastolic murmurs were heard. At the left lateral border of the sternum was a long, loud, harsh systolic murmur. There were a few moist rales over both lung bases, but the abdomen was distended with fluid and there was marked pretibial edema. She was tender over the liver area.

She was digitalized and placed on routine congestive failure management. She improved and continued to take salyrgyn with theophylline, 2 cc. intravenously, once a week. In spite of these measures, in December 1943 she began to feel worse, the abdomen became more distended and, suddenly, one day she had a hemorrhage from the mouth. She was hospitalized at this time and her cardiac status improved.

On March 11, 1946, the patient was readmitted. She had had gradually increasing ascites for a long time until now she was handicaped by its bulk. She couldn't take a step nor could she lie down. Ankle edema was marked. There was dyspnea at rest, which was marked when she tried to talk. Marked distention of neck and arm veins were present. The heart was markedly enlarged to right and left, with the same murmurs and rales over both lung bases. The liver was tender and palpable at least three fingers below costal margin and tender over splenic area. Eight hundred cc. of fluid was obtained when an abdominal paracentesis was done, more or less as an emergency measure. This upset the patient, however, and she was mentally confused for a few days. She responded again to routine measures and was dismissed on April 10, 1946. She was not seen again until December 17, 1946, when she was readmitted with the most extreme ascites. Two paracenteses and usual treatment produced a significant response. On this last admission her liver was five finger breadths below the costal margin and the spleen was three fingers below the costal margin. Both organs were very tender.

Study of the chest films over a period of years is interesting. In July 1940 the heart measured 17.8 cm. compared to a transverse diameter of the thorax of 27.0 cm. It was enlarged to the left and right. The aortic knob was not evident, but from that area to the apex was a straight left border. There was no definite evidence of pulmonary congestion. On December 21, 1943, the heart was 19.0 cm. and thorax 27.5 cm. There was prominence of the pulmonary vessels and conus, with moderate pulmonary congestion. The January 21, 1944, film revealed a transverse diameter of 18.0 cm. and thorax 27.5 cm., with much less pulmonary congestion. This improvement was the result of hospital management. On March 12, 1946, the heart was 21.0 cm. and the thorax 28.3 cm. Her weight was not a definite thing we could consider because of her ascites, but at this time the heart was estimated to be 78 per cent above average normal size. The right border of the heart was indistinct due to marked pulmonary congestion and fluid in right pleural cavity. One month later the heart measured 20.3 cm. and the transverse diameter was 27.5 cm. The fluid and pulmonary congestion was relieved. On December 20, 1946, the chest film revealed marked pulmonary congestion and so much fluid in the right pleural cavity that the right border of the heart was not apparent.

The electrocardiogram on July 26, 1940, indicated a NSR of 80, the PR .16 seconds, QRS .06 seconds, S 1 and R 3 were the predominant QRS deflections, producing an angle of the electrical axis of + 110°. There was slight slurring of the QRS in all leads. T 2 and 3 were inverted.

On December 22, 1943, the electrocardiogram indicated a change from NSR to auricular fibrillation with a ventricular rate of 50 to 60. On March 12, 1946, the angle of electrical axis had increased toward the right to + 125°. R 4 F was now absent. The electrocardiogram on December 17, 1946, indicated a rate of 108. It was very interesting in that an attempt at sinus rhythm was present with the Wenckebach phenomenon.

The laboratory work regarding the blood counts is the thing of interest here. In 1940 the complete blood count, urine, Kline, and gastric analysis were all normal. In 1943 the hemoglobin was 11.6 Gm. (74 per cent), red blood count 4.00, white blood count 3,600, with a normal differential. The blood sugar was 98 and icterus index 12.

On March 14, 1946, her hemoglobin was 9.9 Gm. (64 per cent), red blood count 3.32, and hematocrit 40.5 per cent, making the mean corpuscular volume 122 and mean corpuscular hemoglobin 30. The white blood count and differential and prothrombin time were normal. The total protein was 6.9. On December 18, 1946, the hemoglobin was 10.6 (68 per cent), red blood count 3.81, and hematocrit 44 per cent—making the mean corpuscular volume 118 and mean corpuscular hemoglobin 28. The prothrombin time was now 68 per cent. Within twenty-four hours vitamin K parenterally raised the prothrombin time to 75 per cent, but in 48 hours it was back to 68 per cent. This indicated liver damage. The platelet count was 108,460, icterus index 10, urea 36, and serum chloride 602. The total protein was 6.3 with albumin 3.50, and globulin 2.7, with A/G ratio 1.2/1.

The fluid from the peritoneal cavity had a specific gravity of 1,022 and total protein of 3. The cell count was 2-4 red blood count and 0-1 white blood count per high power field.

This case is interesting from numerous angles, but the reason for presenting it here was the long standing heart disease and the anemia. When she was first seen, six years previously, her complete blood count was normal, but as congestive failure became chronic, with persistent backward failure and congestion in the portal system, anemia made its appearance. The liver and spleen were not palpable when the first examination was made. At the last examination they were greatly enlarged and the anemia very evident.

Discussion

This is a group of cases of rheumatic heart disease presented because of an important secondary effect—that of anemia. Mitral stenosis produces a back pressure. After a few years the right ventricle will fail. Because of the proximity of the hepatic veins and inferior vena cava to the right auricle, any backward pressure is first felt in the portal system. The liver and the spleen, because of its upstream position, are first affected. Prolonged chronic passive congestion produces gross and microscopical changes as already described. With these pathological changes, liver-spleen anemia is likely to develop. The liver and its part in anemia is an established fact. Bile will aid in

the absorption of iron from the gastro-intestinal tract. After absorption the metal disappears rapidly from the circulation and is stored in the liver, and to a less extent in the spleen.[2] If the liver is so damaged by cardiac cirrhosis that it cannot store iron or the antianemic factor, it is definitely contributory to anemia.

In most instances here it was a microcytic hypochromic anemia, but in those cases in which it was a macrocytic anemia, response came with liver rather than iron. So it is important to know the type of anemia one is dealing with; not only as far as the type is concerned but as to its background. Is it due to blood loss, blood destruction, deficient intake of extrinsic factors, or dysfunction of one of the important organs associated with the intrinsic factors, absorption and utilization of antianemic factors? If the heart and cardiovascular system are not placed in the best possible condition, the anemia is not being treated properly. Also, the giving of iron when liver should be used and vice versa is poor practice.

It is felt that this is a definite set of circumstances to be classified as a syndrome; and, certainly, in a complete classification of anemia cardiac cirrhosis should be included.

2. Best, Charles H., & Taylor, Norman B.: Physiological Basis of Medical Practice; Fourth Edition; pp. 58; Baltimore, Williams & Wilkins Company; 1945.

Summary

Six cases of rheumatic heart disease are presented because of the associated cardiac cirrhosis and anemia. The pathogenesis of this set of circumstances is developed. The importance of recognizing this syndrome is stressed.

AIDS FOR DIAGNOSING ANEMIAS IN INFANTS AND CHILDREN

The anemias of infancy and childhood do not differ greatly from those of the adult but diagnosis is often difficult because of the normal blood changes which take place from birth through childhood, according to four doctors presenting individual reports in the July 19 issue of *The Journal of the American Medical Association.*

Carl H. Smith, M.D., from the New York Hospital and the Department of Pediatrics, Cornell University Medical College, New York, points to certain pertinent information which will aid diagnosis, such as the onset of pallor, the appearance of black and blue spots, the loss of blood from the bowel, infection, including exposure to animal parasites, the use of drugs such as the sulfonamides known to affect blood formation, kidney disease, the rapidity of growth, overfeeding of milk with the refusal of solid foods, and the existence of anemia in the mother during pregnancy.

Information in regard to race and nationality is important in the diagnosis of sickle cell anemia, a peculiar red cell deformity, and Mediterranean anemia, says Dr. Smith. Although sickle cell anemia is predominantly a disease of Negroes, it has been observed occasionally in the white families which are principally of Mediterranean origin.

"In Mediterranean anemia," writes the physician, "the patients are mainly of Greek, of Italian (principally Sicilian and from the Italian peninsula below Naples) or, less frequently, of Syrian origin. . . . On the basis of previous studies and of an investigation now in progress the evidence is conclusive that in every family with a child severely affected with Mediterranean anemia and requiring periodic transfusions of blood both parents revealed evidences of the disease."

Wolf W. Zuelzer, M.D., from the Anemia Clinic, Children's Hospital of Michigan and Departments of Pediatrics and Pathology, Wayne University College of Medicine, Detroit, points to prematurity as a cause of anemia. Premature infants usually fail to receive the deposits of iron, building blocks of the blood cell, normally transferred during the latter part of pregnancy and therefore have an inadequate reserve to draw upon for normal growth.

The full term infant usually has an adequate reserve of iron to last until it can be replenished by iron from the diet. Dr. Zuelzer says that "if food rich in iron is not then made available, anemia will develop on a nutritional basis alone. However, a deficiency anemia due to lack of iron is not necessarily the result of inadequate dietary intake; in fact, purely nutritional anemia is relatively infrequent even in infancy. In most instances infection is a precipitating factor."

Analysis of 1,500 consecutive admissions to the Boston Floating Hospital was made by James Marvin Baty, M.D., to determine the incidence of anemia in hospital practice. Dr. Baty is from the Department of Pediatrics of the Tufts College Medical School, the Boston Floating Hospital and the Children's Clinic of the Boston Dispensary.

"It should be pointed out that the Boston Floating Hospital is largely charitable," he states, "and that most of the patients are unable to pay the costs of medical care. The hygienic and dietary background of such a group of children is not comparable to that of patients under the care of private physicians. Furthermore, only those patients with severe anemia and those with unusual conditions received the careful consideration of the hematologist."

Of these 1,500 patients, 514 or 34 per cent, showed a definite anemia. A breakdown by age groups indicates that the second year of life is the period in which there is the greatest incidence of anemia, about 51 per cent. Approximately 45 per cent of the children under two years of age and 25 per cent of those between ages two and 12 were anemic. In 92 per cent of the 514 patients the anemia was the result of infection, dietary deficiency, prematurity or some combination of these three factors.

H. G. Poncher, M.D., Professor of Pediatrics at the University of Illinois School of Medicine, Chicago, states the anemia in infancy is predominantly due to iron deficiency but other necessary materials may also be lacking.

"Such evidence, however," states the author, "does not justify the numerous shotgun proprietary preparations that are constantly offered to the profession without clinical facts to support their use. Preparations of this type increase the cost of medical care and minimize the careful evaluation of the cause of the anemia which is so important to well conceived and intelligent treatment."

Anemia occurring during the age period two to six years is usually due to nutritional deficiency and infection, which interferes with the elements necessary for blood building. Iron and liver treatment produce the best results in these patients after the cause of the infection has been removed.

Anemia during the school age period is predominantly due to chronic infection, chronic inflammatory disease or loss of blood. Streptococcic infections and their complications head the list. Other prominent causes are chronic sinusitis, pneumonia, an inflamed kidney, rheumatic fever and tuberculosis.

Treatment should consist of removing the cause of the anemia, together with the institution of a balanced diet or if the anemia is severe, blood transfusions should be given until the cause is removed.

PRACTICAL OFFICE METHODS OF DIAGNOSIS AND MANAGEMENT OF STERILITY*

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AT THE Cook County Hospital out-patient gynecologic clinic we are constantly confronted with the problem of infertility. Many women seek the reasons and aid for their barrenness. Because of the frequency of the problem, therefore by necessity, all of our clinical diagnostic tests are reduced to practical and simple forms. We have learned that if the procedures are too complicated and cumbersome they lose their practical value and application, thereby leading to fewer correct diagnoses. We should like to present our methods as practiced in the clinic and in our private office. We feel that both partners are equally responsible for infertility, 50 per cent each, until proved otherwise. We shall discuss the female first.

I. *Subjective survey:* We frequently find that when the patient enters the examining room that first "over-all impression" may yield some valuable points in diagnosis. Such conditions as hyperthyroidism, myxedema, phthisis, general debility from various diseases, generalized hirsutism, marked nervousness and anxiety may be detected, and eventually lead to the diagnosis of the condition causing the sterility.

II. *History of: Amenorrhea* may mean congenital defects or absence of the genitalia. *Menometrorrhagia* may suggest abnormal ovarian function. *Mumps* in girls, like orchitis in boys, may lead to ovarian dysfunctions with resultant anovulatory "menstruation." *Acute appendicitis*, with rupture of the appendix, may cause secondary perioophoritis. *Previous laparotomy*, with resultant adhesions, may mechanically block or kink the tubes. *Pulmonary tuberculosis*, with secondary pelvic involvement, must be considered. *Gonorrhea*, with ascending salpingitis, may explain the cause of infertility; pain in lower abdomen, especially during menstruation. *Pneumonitis*, with resultant systemic infection, should be ascertained. We have seen secondary pneumococcic salpinigitis due to pneumococcic pneumonitis. *Psychoneuroses* are becoming important considerations in childless couples. These rightly fall into the category of psychosomatic medicine. We feel that a couple in whom all known tests prove to be negative should be referred to a psychiatrist for adjustment, if indicated. *Endometriosis*—patients with acquired dysmenorrhea in adult life, retroversion and some fixation of the uterus; frequently tender nodules in the recto-vaginal system; metrorrhagia may be present. *X-ray technicians* or girls who work in factories with "radium paint" may be affected by radium. *The use of strong chemical* douches or lubricants during or soon after coitus may account for the sterility. We had several such cases in which the patients used very powerful alkaline vaginal suppositories "to clean themselves."

III. *General physical examination* must be complete and thorough. We have seen pregnancy in the diabetic, in the tuberculous patient, and in some with severe neurologic disease, but we are of the opinion that deviations from the normal may lower the fertility index.

IV. *Examination of the female genitalia:* We reverse our usual routine, and first insert a dry speculum into the vagina to test the PH. of the vagina and cervix, which normally is 4-5 acid and 6-7.5 alkaline, respectively. The nitrazine paper is used as the indicator and the color is compared to the standard chart which is supplied with the paper. We take a nonstained hanging drop for diagnosis of Trichomonas and Monilia. They may cause a vaginitis with resultant sterility.

The *Cervix* is then studied for endocervicitis, ectropions or eversions, and cervicitis; also for polyps and prolapsing fibroids. The canal is probed for strictures. The above pathology is frequently encountered even in the nulliparous woman. It may be slight, moderate, or severe, any stage of which may be the cause of sterility. We do not know what the modus operandi is, whether mechanically the tenacious mucus stops the ascent of the sperm, or if this inflammation gives off a toxin which affects the sperm, but be that as it may, our experience shows that quite frequently, after simple office electrocauterization of the endocervical canal and the erosion or eversion, followed by six weekly dilatations of the canal, many of our patients conceived, some even during the treatment period or within three to six months

* Read before the Thirteenth District of Indiana Medical Society November, 1946.

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thereafter. On the other hand, we have seen cases with very extreme cervicitis, carcinoma of cervix, and cervical polypi who conceived without treatment.

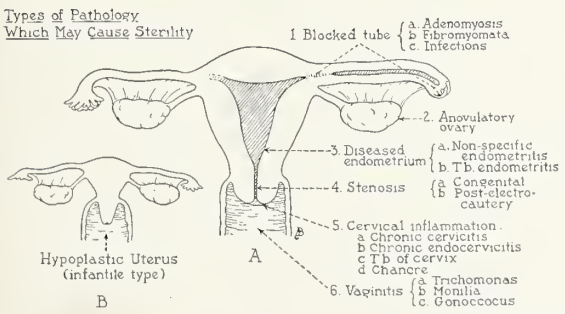
The uterus must be evaluated for size, shape, and consistency. The position of the uterus apparently does not play too important a role in sterility. Occasionally, however, marked retrodisplacement, when corrected, either temporarily by a Smith or Hodge pessary, or by round ligament suspension, is soon followed by conception. It is quite probable that the reasons for conception may be found in the decongestion of the genitalia and restoration of the normal circulation of endometrium and ovaries. We advise our patients who possess a retrodisplaced uterus, which is not corrected, to lie on their abdomen for an hour right after coitus or have coitus in the knee-chest position. This will afford better contact of the semen and cervix. In the uncommon case of uterine prolapse in a nullipara, which may be due to some neurogenic condition, such as spina bifida or some unknown congenital defect, the deposited semen will soon run out of the vagina. There we use a soft rubber doughnut pessary, or try to correct the descensus by surgical suspension.

Hypoplastic or Infantile uterus, in which there is endocrine deficiency resulting in the arrest of the growth of the uterus, is a common cause for sterility. We do not agree with many who state that the above type of uterus will never conceive. We have seen quite a few that conceived without therapy, and some who received therapy in the form of intravaginal heat, the Elliot Treatment, Therma-Flo or diathermy, together with thyroid and estrogenic substance or stilbestrol. However, the prognosis must be guarded in these cases.

Fibroids of the uterus present a combination of cases insofar as fertility and sterility are concerned. We have seen innumerable cases of pregnancy superimposed on fibromyomata of the uterus; others, who were sterile, but conceived after myomectomy; and then, too, those with fibroids and absolute sterility. We have seen irregularities of the uterus which were due to congenital malformations, such as arcuate, didelphys and bicornate uteri, with simple or double cervices and septate vagina.

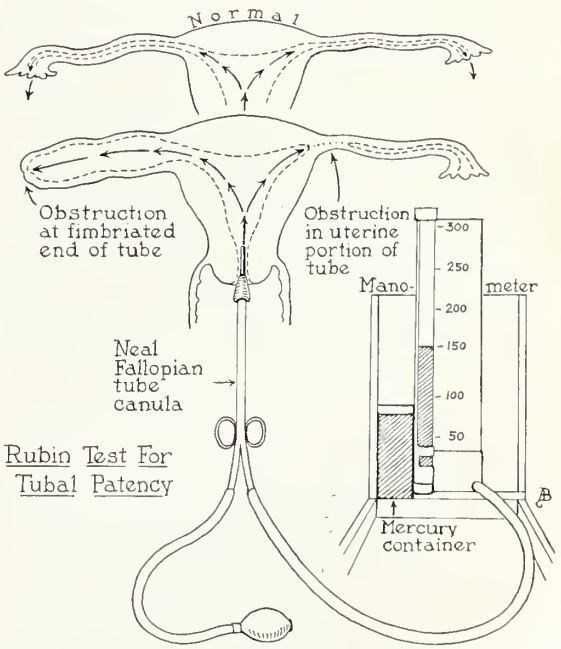
V. *Tests:* Rubin's Test is a very important and essential test in the study of sterility. It should be done preferably in the mid-period. Here we may accomplish two objectives: diagnosis of patency of the tubes, and occasionally the air pressure may open the fimbria (therapeutic). We do *not* perform the test if we find fixation of adnexal structures, pelvic masses, tenderness indicating inflammatory activity, elevated sedimentation rate, or any acute or subacute pelvic disease. The essential and simple equipment consists of a Neal Fallopian Tube canula attached to a blood pressure apparatus and a tenaculum (see Figure II). Be sure to check the canula before its use; the holes at the tip must be open. Not infrequently continual boiling of the canula for sterilization may precipitate some of the minerals and plug up the holes. Also, inspissated blood will block the openings. We also check the canula, otherwise one may obtain a false negative test, thinking that the tubes are closed. With the canula snugly in the cervical canal, and the tenaculum applied transversely on the upper or anterior cervical lip, air is pumped in with the blood pressure bulb. We pump only to 150 mm/hg; if the mercury column drops suddenly to about 90 mm/hg and then gradually drops lower, the tubes are open (positive test). If the pressure remains stationary at 150 mm, the tubes are most likely closed (negative test). If the pressure drops slowly, the tubes may be only partially open or there may be a spasm.

FIGURE I



A. Some of the more common types of pathology which may cause sterility.
B. Hypoplastic Uterus. (Infantile type.)

FIGURE II



Technique of Rubin Tubal Patency Test; upper drawing showing the normal escape of air, while the lower shows obstruction of the tubes.

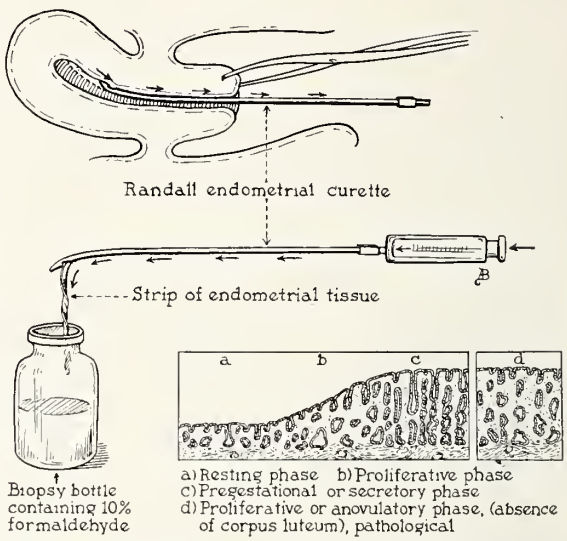
If so, give atropine, gr. 1/150, forty-five minutes before the next attempt. It may be given sublingually or hypodermically. Blonde women are susceptible to atropine reactions, therefore be on the lookout. Do not pump too much air just to see how it works, or to listen to the rush of air into the peritoneal cavity. This is not necessary and is dangerous; air embolism! Sympathetic nerve irritation by too much intra-abdominal air may lead to fainting, nausea and vomiting, and collapse. We have seen all of the above complications. The pain in the shoulder due to the rise of air beneath the diaphragm may or may not develop. If it does, it is confirmatory of the test being positive; if it does not, this is not significant. The pain may last for several hours. If the patient is allowed to lie in a Trendelenburg position for a while (15 to 20 minutes after the positive Rubin test), the air will gravitate toward the pelvis and will minimize the shoulder pain. Be sure to ascertain from your patient whether or not she is able to walk home. Do not allow her to walk away while she feels somewhat weak or dizzy. She may fall and claim negligence on your part and seek medicolegal litigation.

Endometrial Biopsy (see Figure III) is often found to be the missing link in the study of sterility. We have seen many women who come to our clinic who had had all tests made but the study of the endometrium, and it was found to be *anovulatory*. The time for this biopsy is at the height of the secretory or pre-gestational phase of the menstrual cycle, and that is three to five days before the onset of the period. This can be done in your office with complete safety. We do these in the clinic and in our offices. We do not use suction. The cervix is exposed with a speculum, the vagina and cervix are cleaned and painted with merthiolate or any other antiseptic you may choose. The anterior lip of the cervix is grasped with a tenaculum. Do not pull, traction will cause pain; simply hold it in place, pass a small Hegar dilator, if necessary; if the canal is open use a Randall or Novak endometrial biopsy curette. Insert the latter gently until you feel the fundus, then hug the uterine wall, and come out scraping. In this manner you will obtain a substantial strip of the endometrium. Take two or three strips in different sites. Then attach a 5 cc. syringe to the curette and blow out the tissue from the curette into a biopsy bottle containing 10 per cent formaldehyde solution.

If the patient has normal ovarion function with ovulation and corpus luteum formation she will have typical secretory endometrium with long, tortuous, and abundant glandular growth. If she does *not* ovulate, she will present a round, hypertrophied endometrium, the "Swiss Cheese" pattern type which is *anovulatory* endometrium. However, we must bear in mind the possibility that normally ovulating women have an occasional anovulatory cycle. So if we find anovulatory endometrium on the first biopsy we repeat this

FIGURE III

Endometrial Biopsy



Technique of Endometrial Biopsy. a-b-c insert shows the various phases of normal cyclic endometrium. d shows anovulatory endometrium.

for three consecutive months to be sure of her ovarian function. We have found, on routine endometrial biopsy, a case of asymptomatic tuberculous endometritis which was responsible for sterility. Another interesting problem arose when the patient failed to menstruate after the biopsy was taken. She went on to uneventful, full term pregnancy. To avert a possible abortion, take a strip of endometrium from the lateral walls of the uterus where implantation is unusual. We have had no infection or any other complications from our office endometrial biopsy technique.

Temperature graphs for probable date of ovulation are suggested. Rectal rising temperature taken daily will often show a drop of about .6°F. before the ovulation and a similar rise above normal right after ovulation. Abstinence for a week or ten days, followed by coitus at this time may result in conception.

Hühner Test (see Figure IV) is done on every case. Within an hour after coitus the patient is examined. A dry speculum is inserted and the semen is aspirated, with a dry, sterile pipette and bulb, from the posterior fornix and the cervical canal. The semen is examined under the microscope for sperms and in this way we can evaluate the status of the sperm in the vagina and in the cervical canal where they should normally be deposited. The sperm must be viable.

Pre-ovulatory dilatation of the cervical canal is done gently with the hope of mechanically enlarging some of the narrow and small cervical openings, thereby increasing the possibility of impregnation. This is carried out just before the mid-period (see Figure V).

VI. *Laboratory Tests.* These are done to rule out any systemic diseases which may affect fertility:

B.M.R. for hypo- or hyperthyroidism.

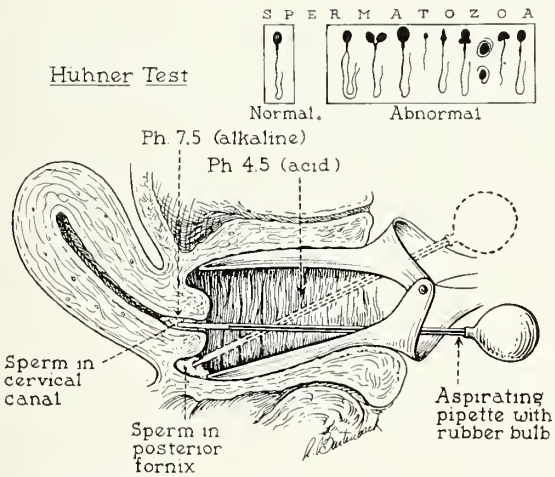
Wasserman and Kahn and Rh. factor.

Sedimentation rate for occult infection.

Urinalysis for pyogenic infection, kidney diseases, and diabetes mellitus.

Complete blood count for anemias and blood dyscrasias.

FIGURE IV



Technique of the Hühner test for sperm viability. Inserts show the normal and the abnormal forms of spermatozoa. Normal PH of vagina and cervix.

Uterosalpingography may be used to corroborate the air insufflation study or to see exactly where the obstruction may be, which of course alters the prognosis. If the obstruction is at the uterine portion, the prognosis is not as good as if the obstruction is at the fimbriated end. When, on the first x-ray study you find the tubes closed, as evidenced by the blockage of the opaque oil, do not accept this as final. We have seen cases which were checked again some three months after the first x-ray study, which showed blocked tubes, and were found this time to be open. It is quite probable that the pressure of the oil may open some of the tubes. Therefore, re-examine your cases again before your final diagnosis is given.

X-ray of chest for possible occult pathology, especially tuberculosis, or residue of pneumococcic or Friedländer's bacillus pneumonitis.

Blood assay of the hormone levels, if such a service is available. This is especially helpful in the hypoplastic uterine sterility cases, also in the ovarian dysfunction cases.

VII. *Treatment of the female:* The approach to the management of sterility will depend upon the etiology.

Inflammatory diseases of the tubes and ovaries are best treated by intrapelvic heat, such as

FIGURE V

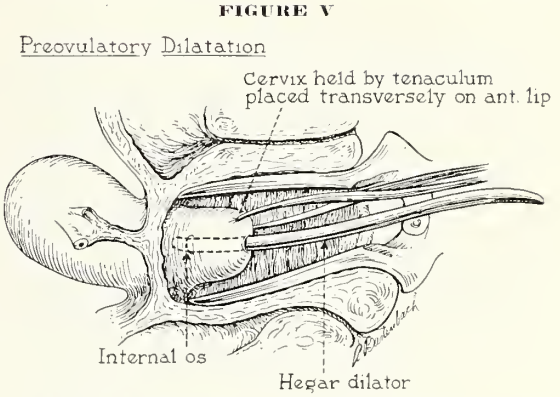


Diagram showing the technique of pre-ovulatory dilatation.

Thermo-Flo, Elliot, or by diathermy. We feel that such treatments must be given frequently, three to five times weekly, to obtain good results. The temperature of the air or water is raised to about 120 degrees F. Some tolerate more heat, others less. Use the patient's own comfortable tolerance as your best guide. We have seen many inflammatory masses shrink following the use of intrapelvic heat; some patients also conceived.

If the patient cannot take treatments at your office for some reason, we advise the "home-Elliot" treatment. It consists of a continuous irrigation of the vagina and pelvis with circulating warm water from the bathtub faucet. The patient attaches the rubber tubing to the faucet and tests the water on her forearm for proper temperature before inserting the tip into the vagina. It must be warm, but not hot; it should flow fairly fast, but with not too much pressure. She spends one hour in the bathtub at night before retiring. This "home" treatment is quite efficacious if carried out as directed. Give the patient simple and understandable directions and demonstrate the actual technique whenever possible.

If the fimbria of the fallopian tubes are sealed by thin adhesions or exudate the above treatment may be very effective. About three to four months following the use of intrapelvic heat therapy we often employ "*The Rubin*" insufflation therapeutically, once a month for from three to six months. The ideal time for such insufflation is prior to the ovulation time, i.e., twelve to sixteen days from the onset of menstruation. We have seen some cases in whom the combination of intrapelvic heat and therapeutic insufflation yielded favorable results. The pressure is not exceeded beyond 150 mm. of mercury. We stress a great deal of potential value of cervical dilatation prior to ovulation.

Pre-ovulatory dilatation is done in the office with a small, sterile Hegar dilator or a sterile uterine forceps. You must do it gently and pass beyond the internal of the cervix. Steady the cervix with the tenaculum, as shown in the diagrams. Do not traumatize, and do not allow douching during this period.

We have noted an interesting anatomic finding in the small hypoplastic uterus. The uterus is frequently acutely anteflexed while the cervix points straight into the vaginal axis, thereby making an acute bend or an "elbow" at the corporo-cervical junction. We feel that mechanically this may hinder the ascent of the sperm. These patients often suffer from severe dysmenorrhea. In these cases we advise dilatation of the cervical canal, straightening out of the uterine axis, and the insertion and retention of the Willey pessary. It must be sutured with silk into the cervix and retained for about three months. Since the original Willey pessary does not have any holes to suture it to the cervix, we made three such openings at 10-2-6 o'clock sites to allow the needle and thread to pass through. These patients carry on their usual sexual activities and menses without any undue difficulties.

In addition to the above measures for the undeveloped uterus we give them thyroid extract, about one grain daily if their basal metabolism is within normal limits; if it is below fifteen we double the dose of thyroid. Injectable estrogenic substance, 10,000-20,000 I. U., is given twice weekly. Oral stilbestrol, .5 mgm. daily, may be tried; if the patient cannot tolerate it, try the natural conjugated estrogenic substance made by any of the leading pharmaceutical companies. We also believe that intrapelvic heat is indicated in these cases to enrich the blood flow to the uterine musculature, which may enhance the growth of the uterus.

Anovulatory endometrium requires the use of synapoidin, a mixture of pituitary-chorionic gonadotropins. Begin with ¼ cc. three times weekly and increase to 1 cc. three times weekly. We believe in frequent and adequate dosages; the occasional medication is of no value. Coupled with synapoidin, use sufficient thyroid to maintain normal metabolism.

The chronic cervicitis should be electrocauterized; the choice time is within one week after cessation of menses. Follow the cauterization by six weekly dilatations of the cervical canal.

Vaginitis must be eradicated. If it is the trichomonas type, we prescribe white vinegar douches, nightly, 2 tablespoons to 2 quarts of warm water, followed by the use of capsules containing a mixture of argyrol, 20 per cent; kaolin 40 per cent; B. lactose 40 per cent. One capsule is inserted deep into the vagina and a sanitary pad is worn so as not to stain the bed linen. Check the progress by hanging drop examination of vaginal secretion for trichomonads.

Monilia, or yeast vaginitis, is treated by thorough cleansing of the vagina and the application of 1-2 per cent of aqueous gentian violet or 1 per cent acriviolet to the entire vaginal mucosa and the labia minora and majora. The latter is often overlooked and re-infection occurs. We have seen many cases of combined trichomonas and yeast infections.

Sexual habits should be concentrated during the ovulation period.

Artificial insemination is still a questionable procedure; however, it should be tried, if the husband is sterile. We have seen a case of an Rh negative woman who aborted twice because of an Rh positive husband. The third time the semen of an Rh negative man was used and she conceived and carried the fetus to an uneventful full term and was delivered of a normal baby.

Surgical attempts to remove or to alleviate the possible etiologic factors in sterility have a place in the treatment of sterility.

In *endometriosis* resection of the diseased ovary and suspension of the uterus may be of value.

Retroversion per se is occasionally the only probable cause for sterility and a pessary or an effective suspension may be indicated. We choose the Barrett type of operation and also the shortening of the uterosacral ligaments at the same time. *Plastic operations* on the distal ends of the tubes may be attempted, but are not too promising. This also applies to the implantation of the proximal ends into the uterine cavity.

In the male the following regime is carried out to ascertain fertility or sterility:

I. *History of the following:* gonorrhea; mumps with orchitis; tuberculosis (pulmonary) or tuberculous epididymitis; hypospadias; premature ejaculations.

II. *Complete and thorough physical examination to rule out the following systemic diseases:* diabetes mellitus; general fatigue (mental and physical); neurasthenia or psychoasthenia; alcoholism; anemias; obesity (simple); obesity (endocrine) (Frölich); hyper- or hypothyroidism; dietary deficiency.

III. *Examination of the genitalia:* congenital defects, hypospadias, sexual underdevelopment, pituitary dysfunction (sexual infantilism); tender and thickened epidymus (G.C.); testes, absent, atrophied, neoplasms; strictures of the urethra; chronic urethral discharges; prostate, inflammations, atrophy and neoplasms.

IV. *Laboratory tests:* Blood count and Wasserman or Kahn; sedimentation rate; B.M.R.; urinanalysis.

V. *Study of the semen:* Should be collected about one week after sexual *inactivity* to yield a normal quantity. We have seen patients with low counts because of too frequent sexual indulgence. Make three different sperm analyses; never make a decision on one. PH. of prostatic fluid in infectious specific or non-specific is about 5.5 to 6.5, which is detrimental to the sperm. Normal PH. is 7.9 to 9.3.

How to collect semen: We advise our patients to use a clean, dry, wide-mouthed bottle or jar, and to discharge the semen either by coitus interruptus or masturbation, to stopper it well and

bring it to the office or clinic within an hour or two after its discharge. The container is carried in the coat pocket. We do *not* advocate any special manner of keeping it warm, as is often done. It is not necessary; room temperature is all that is needed. Do *not* use condoms; these may devitalize or destroy the sperm. *Volume* of specimen should be about 3-4 cc. *Consistency* of semen normally is slightly on the viscid side; if it is too watery, it may be deficient. *Sperm count:* normally about 100 million below 60 million is deficient.

With experience one can gauge fairly well the gross number of sperms when seen under the microscope, which are 15 to 25 per high power field. However, actual count is made by the use of a red blood cell counting chamber, using .5 per cent solution of azochloramid as a diluent, the count is made the same way as a red blood cell count. Draw semen to .5 mark in a white blood cell pipette, then fill the chamber with the diluent, and shake gently; 80 smallest squares are counted; add six zeros; this gives you sperm per 1 cc. of semen. Smear study is made for morphology; that is, normal and abnormal forms. Make a smear as you would for a blood smear, fix by gentle heat, and stain with .25 per cent fuchsin for five minutes, wash in tap water, dry, and examine under oil immersion. Study about 100 spermatozoa and note how many are abnormal; 10 to 15 per cent of abnormals are within physiologic normal range.

Treatment in the male; direct treatment of the etiological factor: thyroid extract, ½ grain t.i.d., or sufficient to maintain normal metabolism; multiple vitamins and B complex; Synapoidin, 1 cc. 3 times weekly (start with ¼ cc. and increase up to 1 cc.; watch for reactions); prostatic massage; psychotherapy.

Summary

1. Practical approach to the probable causes, diagnosis, and treatment of sterility are presented.

2. Various office procedures are outlined as to indications and contraindications and technique.

3. Diagnosis and treatment of both the female and male are discussed.

4. Drawings depicting the above procedures are presented.

Conclusions

We feel that a great deal, if not all, of the essential diagnostic procedures can be accomplished in the office of the average general practitioner. That one must proceed, step by step, in eliminating every possible cause, no matter how insignificant and trite it may appear, is of utmost importance. The need for co-operation for good results must be explained to the patient. *There are no short cuts in this study.* Many doctors attempt blind therapy and thereby do more harm, physiologically and physically.

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MEDIASTINAL TUMORS AND CYSTS

JOHN V. THOMPSON, M.D.

INDIANAPOLIS

THE TUMORS and cysts which have been found in the mediastinum may be classed as follows: tumors of the thymus; lymphocytomas, lymphosarcomas; leukosarcomas, and Hodgkin's disease; neurogenous tumors; dermoid cysts and teratomas; bronchogenic, gastro-enteric, pericardial and echinococcic cysts; lymphangiomas and hemangiomas; fibromas, fibroleiomyomas, fibromyxomas and myxomas; osteochondromas, chondromas, chondromyxomas and chondromyxosarcomas; sarcomas; carcinomas; tuberculomas; hourglass tumors; Pancoast tumors; mediastinal goiters and parathyroid adenomas.

Blades[1] determined that the order of frequency of intrathoracic tumors was bronchogenic tumors, tumors of the mediastinum, and tumors of the chest wall with invasion of the thoracic cavity. Overholt and Souders[2] commented that it was possible for any type of tumor to be located in the chest as all three germ layers were represented in the development of the chest. Harrington[3] stated that the incidence of mediastinal tumors was becoming no greater but better diagnostic methods were disclosing them. In 1932, Haagensen[4] wrote that there were only about 200 primary malignant neoplasms of this region on record. Heuer[5] found that in an experience in a general hospital over a seven year period there were 199 cases of mediastinal disease of which there were 54 cases of conditions other than tumors (emphysema, mediastinitis, tuberculosis of the mediastinum and lymph nodes, as well as nontuberculous lymphadenitis). There were 145 cases of tumor or tumor-like conditions, of which 47 were primary malignant conditions of the lymph nodes. There were 17 cases of other primary malignant tumors and 43 secondary tumors. Benign tumors were present in 36 cases.

1. Blades, Brian: Relative Frequency and Site of Predilection of Intrathoracic Tumors, *Am. J. Surg.* 54. 139, 1941.
2. Overholt, Richard H., and Souders, Carleton R.: Benign Intrathoracic Tumors, *Surg. Clinics N. Am.* 17: 905 (June) 1937.
3. Harrington, Stuart W.: Surgical Treatment of Mediastinal Tumors (Removal of Cystic Azygos Lobe from Posterior Mediastinum), *Ann. Surg.* 96: 843, 1932.
4. Haagensen, Cushman D.: The Differential Diagnosis of Primary Neoplasms of the Mediastinum, *Am. J. Cancer* 16: (pt. 2) 723, 1932.
5. Heuer, George J.: Surgical Treatment of Tumors of the Mediastinum, *Ann. Surg.* 113: 357, 1941.

Blades[6] collected the cases of mediastinal tumors and cysts in which operation was performed in the Army Thoracic Surgery Centers in the United States over a period of 3 years. No neoplasms of previously known lymphoid origin were explored. The series consisted of 114 patients. There were 94 benign tumors and cysts and 15 malignant tumors, plus 5 aneurysms found in the group. The incidence of each type of tumor or cyst was 23 bronchogenic cysts, 20 dermoids and teratomas, 29 neurogenic tumors, 10 pericardial cysts, 6 thymic tumors, 4 lipomas, 1 fibroma, 1 thyroid adenoma, 1 esophageal cyst, 1 osteochondroma, 2 tuberculomas, and 10 of lymphoid tissue origin. A rather complete collection of the cases of these somewhat rare tumors and cysts published in the accessible English literature was reported in another paper by the writer[7]. References to very recent reports are contained in the bibliography of this paper.[8,9,10,11,12,13,14,15,16]

Lemon[17] noted that an intrathoracic mass produced pressure symptoms because the thoracic cage

6. Blades, Brian: Mediastinal Tumors. Report of Cases Treated at Army Thoracic Surgery Centers in the United States, *Ann. Surg.* 123: 749, 1946.
7. Thompson, John V.: Mediastinal Tumors and Cysts. Collective Review, International Abst. Surg. (*Surg., Gyn. & Obst.*), 84: 195, 1947.
8. Clagett, O. T., and Eaton, L. M.: Surgical Treatment of Myasthenia Gravis, *J. Thoracic Surg.* 16: 62, 1947.
9. Dickenson, J. A.: Clagett, O. T., and McDonald, J. R.: Intrathoracic Gastric Cyst, *J. Thoracic Surg.* 15: 318, 1946.
10. Gray, H. K.; Shepard, D. V., and Dockerty, M. B.: Mediastinal Ganglioneuroma, *Arch. Surg.* 48: 208, 1944.
11. Keynes, G.: Surgery of Thymus Gland, *Brit. J. Surg.* 33: 201, 1946.
12. Paul, L. N.: Neurogenic Tumors at the Pulmonary Apex, *Dis. of the Chest,* 11: 648, 1946.
13. Sanes, S.; Maconanus, J. E., and Scotchard, G. N.: Cystic Lymphangioma of the Mediastinum, *J. Thoracic Surg.* 14: 253, 1945.
14. Schlumberger, H. G.: Teratoma of the Anterior Mediastinum in the Group of Military Age; A Study of 16 cases and a Review of the Theories of Genesis, *Arch. Path.* 41: 398, 1946.
15. Stout, A. P.: Ganglioneuroma of the Sympathetic Nervous System, *Surg., Gyn. & Obst.* 84: 101, 1947.
16. Swift, E. A., and Neuhoff, H.: Cervicomediastinal Lymphangioma with Chylothorax, *J. Thoracic Surg.* 15: 173, 1946.
17. Lemon, Willis S.: Rare Intrathoracic Tumors, *Med. Clinics N. Am.* 15: 17 (July) 1931.

in the anterior-posterior diameter was only ½ of the lateral dimension and was made up of an unyielding wall. Harrington[18] observed that tumors in the anterior mediastinum usually caused more subjective complaints than those in the posterior location though the complaints were usually worse in either place if the tumor was malignant. He also felt that tumors in the apex of the chest were more apt to cause symptoms as the space was narrower and many structures were in close proximity. He stated that symptoms depended more on the situation than on the size.[3] Heuer[19] apparently held somewhat the same opinion regarding the size and situation of these tumors. Adams[20] pointed out that the organs of circulation and respiration, the thoracic duct, parasympathetic and sympathetic nerves, and the esophagus were closely related in the space. He observed that if one structure became involved, soon the others were implicated directly or indirectly. He also indicated that the mediastinum could tolerate much displacement from without but very little from within before symptoms occurred. Graham, Singer, and Ballon[21] stated that dyspnea was not always due to the obstruction of respiratory passages but may be due to interference with the pulmonary circulation from pressure.

Heuer and Andrus[19] stated that mediastinal tumors may be asymptomatic or may cause general symptoms due to mediastinal compression such as chest pain, cough, dyspnea, and cyanosis. The common local symptoms, due to the implication of structures adjacent to the tumor, were given by them as visible swelling, dilatation of the veins of the superior venal caval tributaries with edema, inequality of the pupils or Horner's syndrome, hoarseness, dysphagia, herpes or neuralgia of the intercostal nerve distribution, and symptoms that may be referable to the spinal cord. Arthritoid symptoms may be the initial complaint in intrathoracic tumors, as pointed out by Van Hazel.[22] Haagensen[4] also discussed a case of probable dermoid cyst with pulmonary osteo-arthropathy. In the opinion of Hosoi and Stewart[23] there was no pathognomonic symptom or sign that could be trusted in the diagnosis of mediastinal tumors.

Blades[1] was of the opinion that practically all tumors of the mediastinum were malignant, or potentially so, except a few rare cystic types. Heuer and Andrus[19] found in their experience that an occasional tumor may go through life without change but that others demonstrate slow growth. These writers observed that the tumors may become quiescent at a certain point but after several years they may begin to grow again with the production of symptoms, or they may become malignant. Alexander[24] emphasized that, while various signs and symptoms were suggestive of malignancy, such signs may occur with benign lesions as well. It was pointed out by him that the rate of growth did not determine whether the tumor was malignant or benign. He further stressed that the entire body should be examined for metastasis or for the source of a primary neoplasm. Hosoi and Stewart[23] mentioned the frequency of metastasis to the central nervous system. Haagensen[4] felt that symptoms lasting over a year or signs of long duration, such as clubbed fingers and rib deformity, were suggestive of a benign tumor. He was of the opinion, however, that symptoms and signs were of little significance, though extreme findings occurred more often in malignancy.

According to Harrington,[25,3] the value of roentgen rays in the diagnosis and treatment of extrapulmonary intrathoracic tumors was in the earlier diagnosis, therapeutic test response, locating the growth, and in the postoperative management. He stressed the use of various positions and techniques as well as the use of contrast media in the roentgen diagnosis. In his opinion bony destruction of the irregular, infiltrative type was caused by malignant lesions but with benign lesions the destruction was of the erosive, atrophic type. He also stated that a mediastinal tumor which does not undergo a reduction in size with roentgen therapy in the first 7 to 10 days should not be further treated with x-rays, if an operation is being considered.

Heuer and Andrus[19] stated that, in the diagnosis of these conditions, the main reliance was placed on the type of roentgenologic shadow and its location. In their experience a well-defined shadow was more suggestive of a benign lesion, though some malignant ones and even non-neoplastic conditions may cast such a density. It was felt that a diffuse, ill-defined, irregular shadow was most often suggestive of a malignant growth. When a tumor was of large size they were frequently unable to determine the original location. These writers believed that roentgen therapy should not

18. Harrington, Stuart W.: The Diagnosis and Surgical Treatment of Anterior and Posterior Mediastinal Tumors, *New York St. J. Med.* 35: 1073, 1935.
19. Heuer, George J., and Andrus, William DeWitt: The Surgery of Mediastinal Tumors, *Am. J. Surg.* 50: 143, 1940.
20. Adams, Herbert D.: Tumors of the Mediastinum, *Surg. Clinics N. Am.* 18: 3, 629, 1938.
21. Graham, E. A.; Singer, J. J., and Ballon, H. C.: *Surgical Diseases of the Chest,* Philadelphia, Lea and Febiger, 1935.
22. Van Hazel, Willard: Joint Manifestations Associated with Intrathoracic Tumors, *J. Thoracic Surg.* 9: 495, 1940.
23. Hosoi, K., and Stewart, F. C.: Differential Diagnosis of Mediastinal "Tumors," *Arch. Int. Med.* 47: 230, 1931.
24. Alexander, John: Observation on Intrathoracic Neoplasms, *Ann. Surg.* 114: 734, 1941.
25. Harrington, Stuart W.: Surgical Treatment of Tumors of the Mediastinum, *Surg., Gyn. & Obst.* 52: 417, 1931.

be used until surgical removal was considered inadvisable, as that group amendable by surgical treatment, in general, failed to respond to x-rays. They were of the opinion that roentgen therapy failed to prevent malignant change and made removal more difficult because of resultant adhesions; they also felt that it was wasted effort and might be harmful. Primary malignant tumors of the lymph nodes, malignant thymomas, and various mediastinal carcinomas were listed by them as unsatisfactory for surgical treatment, but which might be treated by the use of x-rays.

Alexander[24] observed that while most poorly circumscribed intrathoracic tumors were malignant, benign ones may appear uncircumscribed as well, due to adjacent inflammatory change or atelectasis. He also felt that malignant erosion of the thoracic cage, as distinguished from thinning by pressure, could sometimes be determined by proper roentgenologic technique. In his opinion one of the greatest errors was the use of deep roentgen therapy on a routine basis. He felt that its only proper use, in probably removable tumors, was to determine if a suspected lymphoblastoma were present. He felt that if tumors failed to respond, this did not indicate whether the tumors were of malignant character or not. He stated that if they did respond, much time was lost for extension to occur and the tumors would not be cured, as roentgen therapy had only a palliative value.[26]

In addition to the response of lesions to roentgen therapy, Heuer and Andrus,[27,19] added as further diagnostic aids: bronchoscopy, examination of sputum and pleural fluids for fragments of tumor tissue, aspiration biopsy of lesions near the chest wall, and the removal of accessible lymph glands for biopsy. They pointed out, however, that if a confirmatory biopsy was obtained from a lymph node the operability of the tumor was gone. Alexander[24] felt that the only use of thoracoscopy was in conjunction with the aspiration of fluid with air replacement to determine the presence or absence of pleural implantations of a malignant growth. Harrington[28,3] preferred thoracotomy to thoracoscopy so that the tumor could be removed at the same time, if necessary, and never used the latter in the case of anterior tumors. This authority further pointed out that on bronchoscopy an external tumor was indicated by compression of the visible air passages.[29] He advised against needle aspiration unless the mass was adherent to the chest wall or to differentiate encapsulated fluid from a cyst.[3]. Alexander[24,26] also believed that needle aspiration was not advisable when surgery could be done. He listed the dangers of aspiration biopsy as: hemorrhage, embolism, reimplantation in the case of malignancy, infection of adjacent areas, and empyema, with added difficulty in removal of the tumor. In his opinion a malignant or benign diagnosis did not determine the operability of intrathoracic tumors. This writer also expressed the view that a preoperative pneumothorax could only aid sometimes in the differentiation of pulmonary, mediastinal, or chest wall lesions and still did not alter the indications. In his opinion this procedure was of no compensatory value and he stressed the dangers of tension pneumothorax and empyema. Harrington[3,18,29] mentioned the use of pneumothorax for differential reasons and observed that if the lesions were intrapulmonary the lung collapsed over the growth, though this sign was not infallible. He believed that pneumothorax was of benefit for compensatory reasons but stressed the danger if it were used in anterior mediastinal growths, as they were usually adherent, but stated that the posterior ones were rarely adherent.

Alexander[26] suggested the following aids in the differentiation of intrapulmonary and extrapulmonary lesions: if visible bronchoscopically the tumor was usually in the lung; when a tumor was seen on posterior-anterior, lateral and oblique films, as though interlobar, encapsulated fluid was not ruled out; the use of pneumothorax if no adhesions were present; if the lesion was in the lower chest, not attached to the diaphragm and moved with respirations, it was probably intrapulmonary. He commented that the important thing was whether the intrathoracic tumor was benign or malignant and whether the neoplasm was removable. He stated that the character of the neoplasm could rarely be determined preoperatively except in the case of centrally located bronchogenic tumors, esophageal tumors, and metastatic tumors where a specimen could safely be obtained for biopsy. Garland[30] described a posteromedial line on the roentgenogram, more frequently seen on the lower left side of the mediastinal shadow, which apparently represented the reflection of the medial parietal pleura against the mediastinum. Brown and Robbins[31] thought that the change in contour of the pleural reflection onto the mass suggested a mediastinal location.

Alexander[26] warned against confusion of infectious and suppurative pulmonary diseases, coin-

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cidental to or as a complication of these tumors and possibly hiding them. He considered that the persistence of pain, dyspnea, and cough should suggest tumor. It was also noted that cardiorespiratory disturbances may be caused by a tumor and may simulate the true disease. Alexander and other authors cited in this paper mentioned various other lesions of which one must be cognizant in the consideration of mediastinal tumors and cysts. These lesions will be given, together with references to the literature which may be consulted that contains descriptions of their features. If such descriptions were to be written out here and be of value, it would involve a discussion nearly as long as this paper. Non-neoplastic circumscribed lesions[26] should be kept in mind, such as syphilitic and nonsyphilitic aneurysms of the aorta, great vessels, and heart;[32,21,33] diaphragmatic hernia[3,34] and eventration;[35] mega-esophagus;[36,37] encapsulated empyema;[24,38,39] mediastinal,[40,41,42,43] and Potts' abscess;[42,43] echinococcic, congenital, developmental, acquired, and inflammatory pulmonary cysts;[44,45] a solid or abscessed mass of tuberculous hilar or mediastinal nodes;[42,43] a circumscribed tuberculous or nontuberculous inflammatory mass within the lungs;[24,46,47] atelectasis;[21] and accessory or azygos lobes,[48] particularly if atelectatic or otherwise involved as a whole. Bronchiectasis,[21] mediastinitis,[49,42,43,50] and the causes of superior vena caval obstruction[49,51] need to be differentiated. Pleural tumors[52,1,53,54] and supernumerary pulmonary lobes[48] must be borne in mind. Tumors, cysts, diverticulae and tumor-like conditions such as gumma of the tracheobronchial tree,[24,55,56,21,57,58] esophagus,[21,59,60,37] heart or its coverings,[61,62,21] and diaphragm[63,64] must be considered in the diagnosis of mediastinal tumors. Tumors and chronic granulomas of the bony thorax[1,21,65,28,66] and soft tissues of the outer chest wall, including the skin—occasionally even such conditions of the breast—may cast a suggestive

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shadow simulating mediastinal tumors on a survey roentgenogram but all are frequently palpable and accessible on further examination.[1] The characteristics of the various individual mediastinal tumors and cysts were noted in detail in a previous paper by this writer.[7] In general, besides the usual methods and in addition to the diagnostic means outlined above, the use of contrast media in outlining the tracheobronchial ramifications[57] and esophagus,[60,37] and intravenously to visualize the main intrathoracic portions of the vascular system,[32,67,68] as well as the use of planigrams, plus endoscopy,[32,57,37] may be of value in determining the character of the lesion present.

Heuer and Andrus[19] were of the opinion that tumors, without symptoms or with insignificant signs, may be expected to cause symptoms sooner or later from enlargement or malignant change. From their experience, and from a review of the literature, they suggested that the continued presence of a tumor was of definite danger. Heuer[5] stated that in a great many cases the diagnosis was impossible, particularly as to type, and exploration was the only answer. He felt that large tumors, as such, should not deter operation though they were a difficult mechanical problem, as many were found at autopsy which were removable. The mediastinal tumors that were found surgically removable in his experience were the dermoids, nonmalignant teratomas, other mediastinal cysts, intrathoracic goiters, benign connective tissue tumors including those of cartilage, benign neurogenic tumors, benign thymic tumors, and some sarcomas. Alexander[24,26] believed that intrathoracic neoplasms should be explored if there were no metastases, irremovable invasion of the chest wall, or lymphoblastoma, and the condition of the patient did not contraindicate surgery. He also stressed that benign tumors frequently undergo or tend to cause progressive disability and complications with growth. He indicated that all removable tumors, including the silent type, should be operated on whether or not a preoperative pathologic diagnosis was made. It was further pointed out by Alexander that, since many extrapulmonary circumscribed tumors were malignant, the diagnosis of benignancy was not safe and constituted the most important error made in the management of such tumors. He stated that he had seen many tumors observed and thought benign for months only to find at operation that they had become malignant or inoperable, due to metastasis or invasion. Eggers[53] thought that many more could be removed if diagnosed before they became attached to or invaded other structures. Harrington[3,18] repeatedly stressed the early removal of mediastinal tumors. He stated that the old belief that most of them were malignant and incurable was not true now that early exploration was being carried out.

Overholt and Souders[2] expressed the opinion that exploration of the thoracic cavity could be carried out with as little risk as abdominal exploration and that the results of surgical treatment of benign intrathoracic tumors were equal to the treatment of such tumors elsewhere in the body. Adams[69] also stated that patients with mediastinal tumors could be accorded as safe and as effective treatment as patients in other fields of major surgery. Harrington[25] believed it was demonstrated that malignant tumors could be operated on, with varying degrees of removal, without too great an operative risk. The most important considerations in the surgery of intrathoracic growths, according to him, were early diagnosis, selection of cases, preoperative preparation, approach, maintenance of intrapulmonary pressure, and postoperative supervision. It was his belief that organic or constitutional disease should be treated first, if possible.

The anesthetic procedures used in thoracic surgery were discussed by Wiggin and Schultz[70] and it appeared that positive pressure, intratracheal cyclopropane anesthesia was satisfactory. Harrington[25,3,29] stated that the chief operative problems were pulmonary collapse and mediastinal flutter which could be largely controlled by suitable anesthesia and access to the growth. He used the same types of approach as others but preferred the posterolateral one in most instances. The danger of traction on the mediastinum, adequate hemostasis, and the avoidance of injury to other structures were stressed by him. Harrington also felt that the effusion following extensive extrapleural dissections delayed healing and that a two-staged procedure, with separation of adhesions at the first, was not very satisfactory because of the following pleural reactions. Clagett and Hausmann[71] stressed the marked physiologic change following the resection of large tumors. Alexander[24] preferred the transpleural to the extrapleural approach, as a rule, because of better exposure; since the pleura was usually torn anyway, nothing was gained by an extrapleural approach and it was easier to remove an intrapleural effusion than an extrapleural effusion. The posterolateral approach was used by him, even in the

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case of anterior tumors, for better exposure and accessibility, except in those cases where there was invasion of the anterior chest wall. It was also recommended that removal be done in one stage and that the dissection of the tumor be carried out in the extracapsular plane. The suggestion was also made by Alexander that the vagus nerve be infiltrated below the recurrent branch and the sympathetics likewise infiltrated, if necessary to involve them, to prevent stimulation of these nerves. He mentioned the use of an extrapleural or extraperiosteal dissection, if necessary, over adherent areas and the use of the sacrospinalis to cover the posterior gap in the incision. Alexander commented on the use of drainage where air leaking from the lung could not be controlled and in the presence of gross contaminations. He observed that there was more of a tendency now not to drain, but to aspirate postoperatively and attempt to expand the lung with obliteration of the space to prevent empyema. Eggers[53] also warned against possible postoperative tension pneumothorax and suggested drainage where the possibility existed.

In the techniques described by Heuer and Andrus,[19] the approach depended on the size and location of the tumor. In the case of a small or medium-sized anterior growth, the pectoralis was split and the periosteum divided after subcostal or subchondral resection. If needed, the incision was enlarged by a peristernal incision and the division of the cartilages. For large mediastinal tumors extending laterally, a lateral incision was made with subperiosteal rib resection and division of the periosteum, and other ribs were resected if necessary. Tumors in the upper, posterior mediastinum were approached by a posterolateral incision with retraction of the scapula and subperiosteal rib section. If the tumor was adherent to the lung the latter was cut and sutured, if necessary. If direct vision of the root was not possible, a snare was placed around the tumor which was amputated with later dissection of its root. The chest wall structures were reapproximated and no drainage carried out except in the case of definite soiling, when a drain was placed in a separate stab wound instead of in the incision for fear of infecting the large wound.

Heuer[5] reported in a paper published some time ago that he explored 12 cases of primary malignant tumors of the mediastinum. In 6 patients the tumors were inoperable but in the 6 others the tumors were removed with a postoperative mortality of 16.6 percent and a mortality after removal of 33.3 percent. Two of the patients were living after 2 years, though no 5 year survivals were noted at the time of the report. Operation was performed in 17 cases of benign tumors with removal of the tumor in 16. There were 3 postoperative deaths, plus 1 anesthetic death, for a mortality of 18.7 per cent. One patient later died of a recurrent chondroma. Heuer believed that, with earlier diagnosis and intervention, more cases of malignant tumors would be favorable for surgical treatment and that a greater proportion of patients with benign tumors should be subjected to operation.

In the recent collection of Blades[6] there were 114 patients subjected to operation because of the presence of tumors and cysts of the mediastinum without a death due to the operation.

Graham stated that he knew of no case of malignant mediastinal tumor in which there was a 5 year cure from any kind of treatment, unless the possible exception of Hodgkin's disease with x-ray therapy be so considered. If the interpretation of the case is correct, Harrington[18] reported one patient with a malignant growth in the posterior mediastinum who was living for over 10 years after operation, with no recurrence noted at the time of the report.

Conclusions

These neoplasms are relatively rare. Many of the tumors are malignant or potentially so. The symptoms in general appear to depend on the location, size, and character of the tumor or cyst. There may be general signs and symptoms of mediastinal compression and those of involvement of specific structures. Many tumors may be silent. Roentgen therapy, except as a diagnostic measure where a lymphoblastoma is suspected and as a palliative measure, appears to be of little value.

It would seem that practically any tumor or cyst in the mediastinum should be explored and the neoplasm removed, if possible, providing there is no metastases, irremovable invasion, lymphoblastoma, or secondary malignant tumor, and the patient's condition permits operation. Operation is indicated on account of the doubt in many instances as to the character of the neoplasm and because of the relatively high incidence of malignant types. Operation is also indicated because of the frequent growth of these neoplasms, with consequent symptoms, and because of the frequency of associated infection with its complications. Neoplasms of the mediastinum can now be operated on with about the same degree of risk as that incurred with comparable lesions elsewhere in the body.

THE MANAGEMENT OF DIABETES MELLITUS*

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INDIANAPOLIS

THE basic principles of the management of diabetes have changed very little in the past twenty-five years. There has been a trend towards diets which are more liberal in carbohydrate and protein with a reduction in the fat content. There has also been a definite increase in the total calories permitted per day. Patients' diets today are more appetizing and palatable and, in fact, they are quite comparable to normal diets except for a moderate restriction in the carbohydrate content. With these dietary changes patients are content to adhere to their diets more closely than in the past. The advent of protamine zinc insulin and other modified insulins has been responsible to a large extent for this liberalization in diets and at the same time has helped to bring about a more satisfactory control of the diabetic state with an improvement in the general health of all diabetics.

The clinician who treats diabetes today is interested primarily in the control of the clinical symptoms of the disease and the return of the patient to as nearly normal health as possible. He attempts to prevent the attacks of acidosis and coma and also to avoid the complications of a vascular nature which are too frequently observed in long-standing diabetes. Lastly, he strives to assist the patient in living a useful and happy life for as many years as possible. Most diabetics today are able to accomplish as much in any line of endeavor as is the normal individual and they ask no favors of anyone in the different competitive phases of life. The life expectancy of the diabetic has also been markedly increased in the past two decades.

The physician's secondary interest is in attempting to maintain his patients with normal blood sugars as much of the time as possible and in preventing glycosuria a major portion of the time. Recently such prerequisites have not been deemed necessary by some clinicians. They appear to be content with the presence of rather high blood sugar levels and a rather marked glycosuria much of the time. Their only concern appears to be in the occurrence of fairly large quantities of acid-bodies in the blood or urine of these patients. We do not concur in this opinion. While it has not been definitely proved that long-continued hyperglycemia can directly produce the vascular changes observed in diabetes, we know from long-continued clinical observation of these patients that the individual who will not follow instructions as to diet, insulin, and other details, and who does present such extremely high blood sugars, most frequently is the patient who later in life has the most serious complications of his disease. The widely divergent views as to the most satisfactory treatment of diabetes are due to the fact that it is a chronic disease which varies so greatly in severity, and also to the fact that only a definite percentage of patients seem to possess a predisposition to these vascular complications. This tendency to vascular changes can be observed in the majority of diabetic patients past 50 years of age and is oftentimes noted in much younger individuals who have had the disease in a poorly controlled state for five or more years. It is true that one may observe a severe diabetic, and at the same time an unco-operative individual, who develops few, if any, of these complications, while at other times certain patients who do try to follow instructions fairly closely, and whose diabetes appears to be mild in nature, present the most severe changes in the vascular system. This variance in findings may be due to the hereditary tendency of some patients to develop vascular changes later in life. This is true in the nondiabetic as well as the diabetic patient. If there is a background of vascular disease present in a particular case, this individual surely is the one who should follow the advice of his physician most carefully with the hope of avoiding, or at least reducing, the frequency and severity of such complications.

In recent years great advances have been made in the experimental production of diabetes in animals and it is quite likely that there will be radical changes in our ideas as to the causation and treatment of this disease in the next few years. It is also likely that much will be discovered which will help to prevent many of these dreaded complications.

The purpose of this paper is to outline our concepts of the routine management of the uncomplicated diabetic patient.

Hospitalization

We are convinced that a brief period of hospitalization is of inestimable value to all diabetics. This is true in the mild as in the severe diabetic; in fact, it is in the mild but uninformed patient that we observe the most serious complications. The disease being so mild and insidious may present symptoms which might be overlooked by the patient not trained to be on the alert for their appearance. The mild diabetic is the one who lives to such an age that he is more prone to develop these vascular changes which are capable

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of producing invalidism in the later days of life. We are therefore trying to encourage hospitalization in as many instances as possible, for the purpose of training and instruction as to the management of the disease.

a. Diets

Here the patient is taught the basic principles of dietary management. Either he or some member of his family is instructed in the compilation of his diets. This we insist upon so that at subsequent times dietary changes can be made with as little disturbance to both the patient and ourselves as possible. We have observed that many patients desire more carbohydrate or more protein and less fat as time goes on, or they may in a few instances want to use diets which are higher in fat content. If the patient understands how to make up his own diets these changes can be made very quickly without the necessity of our showing him how to make substitutions, or without the aid of the hospital dietitian. We have never employed any set formulae for our diets but try to prescribe that food quotation which we feel will suit the individual patient. Our initial hospital diet is usually about 130 grams of carbohydrate, 90 grams of protein and 90 grams of fat. When the patient becomes sugar free on this quotation, the carbohydrate is increased about 20 grams at a time until it is usually built up to 200 grams or more of carbohydrate per day. At the same time we frequently lower the fat content to 70 or 80 grams per day. Changes in the diet formulae after dismissal from the hospital are in keeping with the dietary desires of the patient and the degree of diabetic control as observed from time to time. We must at the same time consider changes in body weight and also be guided to a great extent by the activities of the patient in selecting the permanent diet. Every uncomplicated diabetic on entering the hospital is given a trial for a few days on dietary measures alone. If, at the end of this time, the blood sugars continue to run above the normal levels, and if he is showing sugar consistently in the urine, insulin treatment is started.

b. Fundamentals of the Disease

Once the dietary calculations are mastered, the patient is taught to test his urine for sugar and diacetic acid. He is required to make these tests before each meal and at bedtime throughout his stay in the hospital. These are single collections of urine and help to guide us in adjusting the patient's insulin dosage. When once the patient is permitted to leave the hospital he is requested to make urine examinations once or twice daily, and special forms are supplied for keeping a record of these tests. These reports are studied at his subsequent office visits.

A diabetic manual is furnished each patient upon admission to the hospital, and if he is not too ill he is quizzed daily by the nurse as to the fundamentals of treatment as outlined in this manual. The nurse also teaches the patient or some member of his family the ABC's of his disease. He is instructed in the symptoms of insulin overdosage and what to do to antidote this condition. He is advised what to do if infections of any type present themselves. He is specifically taught never to omit insulin in the presence of infection even though he has little or no desire for food. In fact, he is advised at such times to increase his insulin if his urine tests, made several times daily, denote the presence of sugar or diacetic acid. Patients are instructed to call us immediately upon the onset of any infection or other untoward symptoms. He is advised how to prevent or overcome acute gastro-intestinal upsets. He is drilled especially in the causation, symptoms, and the prevention of acidosis. Lastly, he is instructed as to the proper care of his feet. We make ward rounds daily and try to teach each patient as much as possible regarding his disease and its proper management. All of this is time-consuming but we feel it pays dividends in the future co-operation of the patient and in the prevention of many annoying difficulties in the months and years to follow. We believe that the best co-operation comes from the informed or well-trained patient who understands the peculiarities and idiosyncrasies of the disease and who is quick to recognize the early danger signals of approaching acidosis or infection.

Check-ups Following Hospitalization

Once the patient has been dismissed from the hospital we make it a point to check up on him at weekly or monthly intervals for the first three or four months, and after that he is seen at three- or four-month intervals. This means that the patient must to a great measure be his own physician much of the time. When he calls at the office he brings with him a list of questions in regard to the problems which have arisen since his last visit, and we try to instruct him as to how to overcome these difficulties should they present themselves again. We marvel at the manner in which many well-trained diabetics can care for themselves during acute infections and even in occasional bouts of acidosis. Many of our patients travel to different parts of the country at different times of the year and they seem to be able to take care of themselves in a most satisfactory manner. Once the patient has been taught the proper care of his disease he is not going to be off guard very frequently. We have found that many of them have managed surprisingly well under the most extraordinary circumstances.

Insulin

Once the patient has mastered the details as to diet, urine examinations, and the fundamentals of his disease he is taught how to use insulin. This, we feel, is necessary in over 80 per cent of our patients. Quite frequently we find that the milder

cases may only require protamine zinc insulin for a period of a few months, as they gain remarkably in sugar tolerance and are able then to discontinue the insulin and continue to follow a weighed or a very carefully measured diet. These individuals know that if infection or some other complication presents itself they are to return to insulin during the period of such an emergency.

Many of the older patients need only a single injection of protamine zinc insulin per day, while other younger, and possibly more severe cases, use separate injections of unmodified and protamine zinc insulin one or more times per day. We try to adjust the insulin dosage according to the blood sugar level of the patient in tests taken both in the fasting and postprandial states. We do not hestitate to suggest one or more extra injections of insulin per day if we feel they are necessary to maintain a fasting blood sugar between 80 and 120 milligrams and a postprandial blood sugar (4 hours) of between 120 and 180 milligrams. This is not always possible with any arrangement of diet and insulin but it does give us some goal for which to strive.

We do not use mixtures of unmodified and protamine zinc insulin very frequently as we have observed rather marked fluctuations from time to time when the different percentages of these two types of insulin are mixed together. We do have a number of milder diabetics who get along very nicely on these mixtures with apparent good control, but whenever they begin to show sugar or their blood sugars are high they will often, of their own accord, return to separate injections of the two different types of insulin.

We have yet to see an intelligent, co-operative patient who has objected to one or more extra injections of insulin per day. Most of our patients are concerned with keeping their diabetes under control and in maintaining a satisfactory state of health. In fact, many of our patients who are physicians, nurses, and teachers, who check their urines frequently, tell us that when they show 1 per cent or more sugar they voluntarily take an extra injection of insulin one or two times daily until the glycosuria subsides. These patients are interested in good diabetic control as much of the time as possible, and not in the avoidance of a simple, painless procedure such as an extra insulin injection. Many of our severe diabetics boast that they have taken insulin three to five times daily for twenty-three or more years. Throughout all this time many of them have worked every day, have never been returned to the hospital because of any illness, and quite a few of them present no apparent complications of their disease. There is much satisfaction to a physician to see these severe diabetics live an active life for such a number of years and have them appear to be in such an excellent state of health.

We believe that the maintenance of normal or nearly normal blood sugar levels for 24 hours a day allows for a gain in carbohydrate tolerance of our patients and certainly it prevents many of the complications of the disease.

Check-ups

The average uncomplicated diabetic who is intelligent and who applies himself to his studies usually remains in the hospital for an average of seven days. Occasionally he may be forced to remain as long as fourteen days, depending upon how well he applies himself and also upon the severity of his disease. We do not feel that the final stabilization of his diabetes can be obtained during this brief period of hospitalization, because his life here is so regimented and his activities so greatly restricted. When he returns home and takes up his regular activities he usually gains very rapidly in carbohydrate tolerance. It is because of this rapid improvement that we have the patient return to the office for a series of blood sugars in ten to fourteen days after dismissal from the hospital. His diet is usually increased at this time and the insulin dosage altered if he has been sugar free on most all tests, or if he is experiencing any insulin reactions or other disturbing symptoms. Following this initial check-up the periods for subsequent examinations are greatly lengthened so that the patients are seen on the three-or four-months' schedule aforementioned. At the time of each office visit a report is submitted by the patient of his daily or semi-daily urine tests. He also submits 6- or 12-hour urine samples for examination. The patient discovers quickly what changes he desires in his diet, and if the blood sugars are normal and other findings are satisfactory, we are only too glad to make such increases in carbohydrate or protein as he so desires. About 90 per cent of our patients have food scales and most of them use them at all times. A few of the milder cases follow carefully measured diets. By so doing there is a marked gain in carbohydrate tolerance in over 70 per cent of the patients; however, this gain in tolerance has not been observed in the juvenile cases. Nevertheless, improvement in the juvenile cases is observed as they reach maturity. The most marked gain in tolerance, as would be expected, is in the obese patients who show a marked weight reduction. Many of these are permitted to discontinue insulin after a period of two to six months, and when observed over a period of several years they will continue to show normal blood sugars and have no sugar in the urine. In the young, thin, and active diabetics higher diets are prescribed from time to time. This may oftentimes be accomplished without greatly increasing the insulin dosage. The thin patients are a little more difficult to manage because they are frequently insulin-sensitive and are prone to hypoglycemic reactions. These reactions are seldom observed in the obese patients.

The diets which we use are made up mostly of equal meals with a feeding of 15 to 25 grams of extra carbohydrate at bedtime. This can be taken

in the form of crackers and milk, orange juice, cereal and cream, or fruit. Occasionally unequal meals are used if the patient so desires, or if better control of his diabetes is possible by such an arrangement. Many patients state that they like a smaller breakfast with a larger evening meal, while in other individuals the reverse is true. Children of school age are given high-carbohydrate and high-protein diets with a mid-morning and mid-afternoon feeding as well as food at bedtime.

Insulin reactions occur most frequently in the young or in severe diabetics. Fortunately, the extremely severe reactions are seldom seen because the patient or some member of his family is taught to be on the lookout for the initial symptoms of hypoglycemia. Insulin overdosage as the result of an excess of unmodified insulin usually occurs a few hours after the taking of food and in the majority of instances is readily apparent to the patient so that he can antidote it with a small amount of orange juice or half of a bottle of Coca-Cola. We do not advise our patients to use candy or sugar very frequently to overcome reactions. We have found that when such excessive sweets are used the patient will often take them in excess, and he is then likely to show sugar for several days afterwards. Protamine insulin reactions are prone to occur at any time, but most frequently after retiring or in the early morning hours. They develop so slowly and insidiously that the patient oftentimes sleeps through the initial symptoms and may be found in a severe convulsive seizure which demands immediate attention and the administration of larger dosages of glucose. This is preferably given intravenously. These reactions occur most frequently in the juvenile diabetic and for this reason we insist that all younger patients, on leaving the hospital, be provided with ampules containing 20 cc. of 50 per cent glucose which are kept in the family icebox at all times to be used in such emergencies.

In teaching patients we try not to alarm them in regard to the danger of the milder insulin reactions. Many patients develop a fear of reactions bordering on a phobia, and oftentimes imagine that their blood sugars are running low, when actually they are fairly normal or even above the normal level. Diabetic patients are inclined to believe that most all symptoms which they observe from time to time are due to either high or low blood sugars. We try to disprove this fact to them, and try to allay their fears in this regard, and insist that they not use such large amounts of carbohydrate which, in turn, may upset their diabetic status for a day or so. We believe that the milder reactions occur in those patients who are possibly under the best diabetic control. The patients who state that they have never experienced insulin reactions are oftentimes those who do not follow a diet, who have made no urine examinations, and whose blood sugars are extremely high much of the time. Mild insulin-shock at occasional intervals may even be beneficial in bringing about a gain in sugar tolerance.

We try to maintain the blood sugars at fairly normal levels in patients who have been dismissed from the hospital. At each visit at the office the tests are made four hours after breakfast and four hours after a weighed lunch. Infrequently we take fasting blood sugars and, if necessary, a blood sugar test at 9:00 or 10:00 P.M. In this way we have a fairly good perspective of the blood sugar levels throughout the day. The fasting blood sugar gives us information as to the proper amount of protamine insulin the patient requires. The 11:00 A.M. blood sugar gives an index as to the amount of regular insulin to be administered before breakfast, while the blood sugar at 4:00 P.M. indicates the amount of unmodified insulin necessary to be taken before lunch or the evening meal. With this in mind, normoglycemia can oftentimes be maintained throughout the 24-hour period.

Summary

In conclusion, we believe that all diabetics need hospitalization and training. It is only in this way that the physician can evaluate the severity of the patient's diabetes. This also allows for a careful general physical check-up during this period. One can determine whether or not complications of any kind have developed and, if so, one can give valuable advice to the patient as to how to prevent further advancement of these complications as time goes on. This period of hospitalization also allows time for careful training of the diabetic and for detailed studies which are of great value to the patient and the doctor throughout the years to come. The ability of the patient to learn the compilation of his diets allows for more food and a variability in his diets from time to time. This helps to prevent the monotony of such diets and allows for better co-operation on the part of the patient. The patient who understands foods and the proper arrangement of his diets is less likely to become careless and indifferent in this respect after his dismissal from the hospital. We are quite convinced that very little can be learned by routine office calls by the diabetic to the physician's office unless he has had previous hospitalization. Few doctors have time to spend an hour or more at each office visit with these patients to teach them these basic principles of their disease. Lastly, we have observed that the picture of the disease during hospitalization changes almost daily for the first seven to ten days, and therefore frequent changing of the diets and almost daily manipulation of the insulin dosage is required during this period.

There is nothing new presented in this paper, simply an outline of the procedures which we have found essential in treating a fairly good number of diabetic patients during the past twenty-five years.

CIRRHOSIS OF THE LIVER: PROSPECTS FOR EARLIER DIAGNOSIS AND TREATMENT*

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INDIANAPOLIS

TO review successfully the evolution of present concepts of cirrhosis of the liver, much less the various forms of hepatic insufficiency, would be an encyclopedic enterprise. From two points of view alone we are brought to a halt in attempting any comprehensive review of the subject: (1) the voluminous literature of the clinicians and pathologists and, (2) the tremendous literature of the past ten years in the field of biochemistry and physiological research of liver function and metabolism in general. Of practical progress in one direction, however, there can be no doubt: the increasingly accurate findings in cellular physiology, more particularly in the direction of protein metabolism.

As a practical step in a better understanding of cirrhosis of the liver, the practicing physician must admit up to now his failure or inability to utilize the information provided by the research doctor and the biochemist in detecting early cases. In the practitioners' defense, however, it must be said that the pertinent findings of the researches are highly scientific and the interruption of years of war have not been helpful in obtaining a practical summary for clinical use.

Likewise, diligent work by the pathologists cannot serve as a very useful guide for the clinician because the pathological conclusions vary most widely from the simple dicta of Fiessinger: "There is only one cirrhosis," and Josselin de Jong: "There is only one cirrhosis but with many clinical variations, types and anatomic pictures. These depend on etiology, nature and activity of the injurious agent, portal of entry, duration of the process, age, sex and individual resistance, peculiarities of race and constitution, climate and environmental factors." From these statements proceed more intricate and elaborate classifications in which the pathologists themselves are confused and lost in a maze of overlapping impressions. Therefore, there is now some question as to whether it is justifiable to attempt to sub-divide cirrhosis into sharply defined types or forms.[1]

Many cases of cirrhosis are discovered at the time of abdominal exploration or at autopsy. Cirrhosis of the liver may have run its course, may have been arrested, and may have left only structural liver changes without having caused recognizable symptoms.[2] One condition justifies comment at this point, namely: sudden death in young adults in the association with fatty liver.[3] Little is known about it and not much has been written, although case reports are increasing. Sudden deaths in second, third, and fourth decades are usually attributed to acute coronary disease or cerebral vascular accidents. However, sufficient autopsy reports are available to demonstrate a group of cases (usually alcoholic) in which sudden death occurred and the only demonstrable lesion was a large, fatty liver. Theory only prevails in regard to these cases, and severe vitamin storage deficiency plus fulminant hypoglycemia are offered as explanations.

Advanced cirrhosis of the liver, with hemorrhage, cholemia, toxic manifestations, ascites, profound alterations of the collateral circulation, hepatic coma and death, is often dramatic in its course, familiar to us all, and verified many, many times at the autopsy table. No further comment on this phase of cirrhosis is needed. What we are interested in is improved diagnostic methods whereby early cases may be detected and irreversible liver damage prevented by prompt and adequate treatment.

Early symptoms and physical findings might best be sought for with an understanding of physiological defects listed under the following: (1) Parenchymal defects: mild; (2) Parenchymal defects: moderate; (3) Primary vascular, circulatory and hemodynamic defects; (4) Primary biliary stasis or failure; (5) Parenchymal vascular defects; (6) Parenchymal biliary defects.[4]

Considering the vagueness of the early phases of the disease, which individuals are most likely to develop cirrhosis of the liver? Constitutional pathology is a system of study designed to classify groups of individuals of certain body habitus who may fall prey to certain diseases. The "bilious habitus and temperament" was dealt with at length by the ancients in humoral pathology. In modern times an attempt at more accurate description and anatomical analysis has been made by Pende and Naccarati.[5] They state: "Certain individuals have the characteristics of the so-called bilious temperament. The production of cholemia

* Part I of a Symposium presented before the Indianapolis Medical Society, at Indianapolis, April 8, 1947.

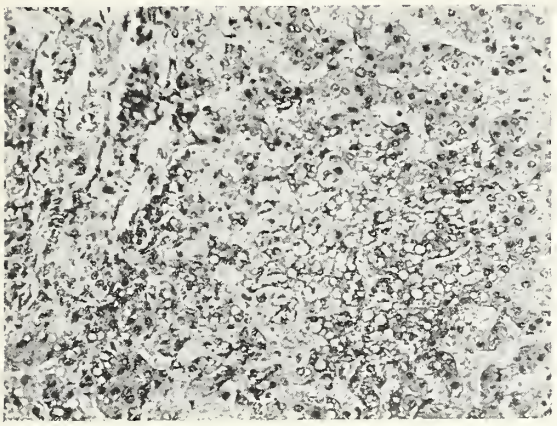
1 and 2. Tumen, H. J.: Diseases of the Liver, Bockus-Gastro-Enterology, Vol. II, p. 295.

3. Graham, R. L.: Sudden Death in Young Adults in Association with Fatty Liver, *Bull. Johns Hopkins Hosp.* 74:16, Jan. 1944.

4. Lichtman, S. S.: Hepatic Insufficiency: Pathophysiology and Clinical Aspects, *Ann. Int. Med.* 25:453-465, 1946.

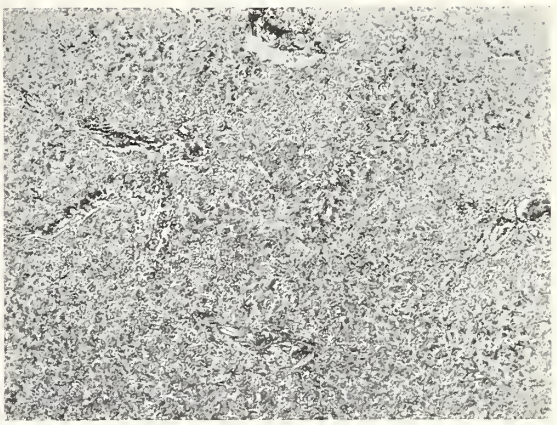
5. Pende & Naccarati: Constitutional Pathology, Lea & Febiger, Philadelphia, 1928, p. 185.

FIGURE I



Photomicrograph, high power, showing advanced degeneration of liver cells, with general fatty change and multiplication of bile ducts.

FIGURE II



Photomicrograph taken with low power, showing disorganized liver substance, marked connective tissue increase.

by a minimal amount of circulating bilirubin with a minimal physiological icterus portrays the bilious constitution or the hepatic soil. These subjects are said to be, in fact, predisposed to all hepatic diseases, especially to gallstones, infectious jaundice, cirrhosis, primary carcinoma of the liver and even echinococcal disease. They can be recognized by their olive or brownish-yellow or livid pale complexion, abounding in pigmentary disorders and vascular moles or naevi and in coffee-colored blemishes known as liver spots and by presence of xanthomata on the eyelids, due to a hypercholesterinemia of variable severity, a result of hypercholesterinemia following hepatic insufficiency. These individuals often show, also, bradycardia, arterial hypotension, hypothermia, hypersensitivity to cold, asthenia, apathy, psychic depression, irritability, hypochondria, somnolence after eating and constipation."

The above group of individuals may be recognizable as likely prospects for cirrhosis of the liver but this disorder is not strictly limited to these body types.

The fetor hepaticus (the amine odor of the breath) is of interest but cannot be universally applied as a criterion of potential cirrhotic patients. In advanced cirrhotics it is more constantly observed.

History of Patient

Before attempting a study of diagnostic procedures the history of the suspected cirrhotic is important. Age, sex, race are catalogued routinely. Occupation, with especial queries, especially as regards prolonged contact with alcoholic beverages, is important.

Alcoholism must be appraised discreetly for the statement of the patient is not sufficient. Many alcoholics are notoriously untrustworthy as to statement and behavior. A better idea of the extent of alcoholism may be obtained from family, relatives, and friends.

Past-medical history-taking should emphasize previous diseases suffered and treatment administered, e.g., jaundice, biliary tract disease, and other systemic infections whereby history of arsphenamine, cincophen, atabrine, or quinine therapy has been used extensively.

History of proctitis, sigmoiditis, and infectious colitis are pertinent because of the implied role of bacillus coli, allied bacterial groups, and streptococci in producing hepatic cellular damage via the portal system.

The opportunities for follow-up studies in the Veterans Administration for service men of World War II, relating to infectious hepatitis and serum hepatitis cases, are unlimited. The Veterans Administration possibilities will probably exceed the opportunities for long range sequential studies available in medical clinics, and particularly gastrointestinal clinics, where the most accurate studies have been completed to date.

These clinical studies emphasize the importance of understanding the mechanism of liver vulnerability via the portal vein, hepatic artery, and the biliary ducts.

Etiology

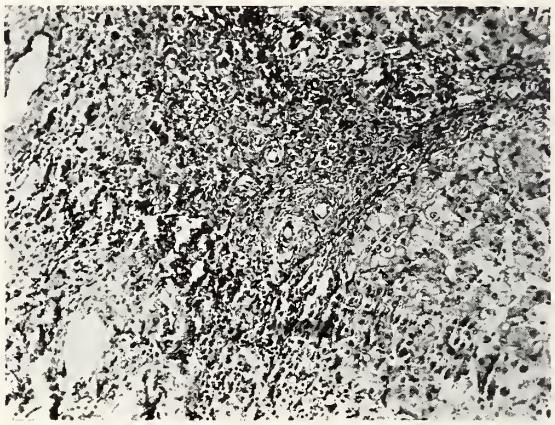
Cirrhosis shows greatest clinical recognition in the fifth decade; the ascitic stage in a large series shows age 54-plus as the average. Racial extraction has shown the Irish and Italian as especially vulnerable. More information about the dietary habits of these people is needed. Ingestion of alcohol in large amounts over long periods by some individuals without cirrhosis indicates that alcohol is not the sole factor in the production of cirrhosis. Dietary disturbances incident to chronic alcoholism produce a vicious cycle of anorexia, nausea, and food intolerance, whereby lack of meats and dairy products are outstanding. The cirrhotic, in other words, sacrifices essential foods and elementary amino-acids to a dangerous intake of alcoholic beverages.

FIGURE III



Photomicrograph, high power, showing atrophy of liver lobules, enormous increase of perilobular connective tissue, and advanced atrophy of liver columns, with marked fatty change.

FIGURE IV



Photomicrograph, high power, showing enormous increase of perilobular connective tissue, with multiplication of bile ducts and atrophy of the liver cells of massive type.

Alcohol is therefore highly important as an antecedent agent acting specifically to produce fatty degeneration. It may possibly induce cirrhosis by leading to the formation of unknown sclerogenic poisons or by enabling such agents to act upon the hepatocytes.[6]

Poetically, chronic alcoholism and cirrhosis are described in the classic of American free verse, "Spoon River Anthology," by Edgar Lee Masters,[7] the Chicago attorney, biographer of Abraham Lincoln, and later turned poet. His quaint verse on Deacon Taylor, as one of the deceased villagers speaks, goes as follows:

"I belonged to the church,
And to the party of prohibition,
And the villagers thought I died of eating
watermelon.
In truth I had cirrhosis of the liver,
For every noon for thirty years,
I slipped behind the prescription partition,
In Trainor's drug store
And poured a generous drink
From the bottle marked
'Spiritus frumenti.'"

Chronic or recurrent hepatitis may very probably gravitate into cirrhosis of varying degree. It is now highly probable that we have been too lax in allowing these cases to resume activity under 50 or 60 days. This was proved by the Army Air Force in the Pacific Theatre of War. Here infectious jaundice cases were permitted to be out of bed at varying periods of time for a full days' average activity. Cases showing no evidence of clinical jaundice, thus systematically exercised, showed at the end of 12 hours varying degrees of hyperbilirubinemia.

Two paradoxes in the age-long argument of the alcohol-cirrhosis complex are noteworthy: first, the relatively minor percentage of clinical cirrhosis in the estimated 3,000,000 alcoholics of the United States, and second, the low rate of incidence of alcoholic neuritis in cirrhotics.

Symptoms

The ability of the liver to withstand damage and then re-establish functional integrity is prodigious. This ability depends upon adequate nutritional balance and a relatively intact portal system. Even severe, widespread hepatic insufficiency is often difficult to detect because of the multiplex versatility of the organ; multiplex in that it is a secretory agent for the gastro-intestinal tract and a potent endocrine-metabolic structure.[8]

Portal cirrhosis may be latent and may be revealed after death from other causes. Perhaps 50 per cent of cirrhotics are never diagnosed as such. Symptoms may be absent even in the presence of advanced pathology so long as an adequate collateral circulation is maintained. The pre-ascitic stage is often more prolonged than is indicated by clinical signs and unfortunately is seldom recognized at this time when the symptoms are chiefly gastro-intestinal in phase.

Submerged below the level of clinical recognition for years, the period of fully recognizable cirrhosis is only a small fraction of the entire life history of the disease.[1]

The liver is noted for multifold depression of numerous functions, rather than single functional alteration, which accounts chiefly for vagueness and complexity of symptoms. The order, rate, and severity of their appearance depends on the progress of exhaustion of the hepatic reserve and final inability of the liver to regenerate new cells.

6. Rolleston & McNee, Diseases of the Liver and Gallbladder—Ed. 3-London, McMillan Co., 1929.
7. Masters, Edgar Lee: Spoon River Anthology, New York, The MacMillan Co., 1916, p. 50.
8. Eliot, C. H. & Nadler, W. H.: Diseases of the Liver, Tice Pract. of Med., Vol. VII, p. 59.

Vagueness of onset, anorexia, dyspepsia, bloating, belching, excessive eructations, persistent indigestion for years, vague indefinite pain of the upper abdomen, and indefinite symptoms of mild intoxication, malaise and biliousness, parallel the speculated period of mild parenchymal insufficiency of the gastro-intestinal complex phase of the preascitic stage.

The moderate stage of insufficiency in the preascitic stage is perhaps represented by mild transient jaundice, sallowness, change of bowel habit in a trend towards diarrhea, variations in stool color, weakness, variable weight loss, transient mild edema of the ankles, and fat intolerance. This phase is theoretically supposed to represent the onset of failure of protein synthesis, early disturbance of the albumin-globulin ratio of the serum, and failure of the lipotropic action of certain amino-acids.

Epistaxis, hematemesis (which occurs in 25 per cent), and gross hemorrhage from strategic points of the collateral circulation often appear at the transition stage of moderate to severe parenchymal destruction. The strategic points of gross hemorrhage are the esophageal varices, the left coronary vein of the stomach, and the middle hemorrhoidal plexus in its anastomosis with the inferior mesenteric plexus.

Pruritus (often estimated as present in 67 per cent of cirrhotics and often of the nocturnal type) may be present throughout all phases of the disease, from mild to terminal. The dermatologist might well become "liver-conscious" in approaching many cases which consult him for intractable pruritus alone.

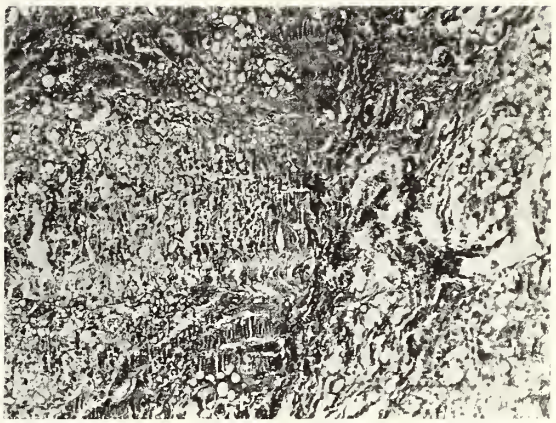
Neuropsychiatric symptoms in mild degree may appear early in the form of apathy, loss of power of concentration, restlessness, insomnia of the midnight to early morning type, hyperacusis to nocturnal sounds, mild confusion, restless sleep with muttering, and postprandial somnolence. Severe anxiety states, mild delirium, delusions, and personality changes may thrust the patient into the care of the neuropsychiatrist. The milder disorders may erroneously lead the neuropsychiatrist, internist, or general practitioner to conclude his analysis with the diagnosis of neurosis or hypochondriasis.

Physical Examination

The tendency of the physician to relegate liver disease to fields beyond the pale of physical examination and, in turn, to diverge to the laboratory for aid is a reprehensible error. The medical history and physical examination are far more important than laboratory aids. The present status of liver function tests is, in the main, impractical, ambiguous, and uninformative unless careful group comparison of selected functional tests is made.

The visual memory of the examiner of the hepatic habitus, plus observance of sparse body-hair distribution, and a broad subcostal angle may be of aid in gross inspection of likely suspects for cirrhosis.

FIGURE V



Photomicrograph, high power, showing detail of perilobular connective tissue increase, considerable disintegration of liver cells, and advanced fatty change.

Examination should be made under good natural light. The suspicious mousy-musty odor of the subject under examination should be noted, as well as the amine-like odor of the breath (the so-called hepatic fetor). Gross pigmentary bronzing changes of the skin can be readily seen, while a general, mild, muddy subicterus may underlie the pigmented patches. The facies can be studied and the thin, drawn countenance, compared to gross body-weight maintenance, can be observed in some subjects. Bleary eyes, with conjunctival irritation, are often obvious. Mucosal-membranous changes, with dark-brown, chocolate-like discoloration, are occasionally noted and the furrowed, lightly-coated tongue seen. Quite often the tongue is uniformly smooth and red but not glazed to the point of atrophy, as seen in primary pernicious anemia.

General inspection of the entire body surface is one of the most informative of procedures. The skin texture generally is dry and scaly. Scratch marks may be fresh as evidence of marked pruritus of the torso and lower extremities. The scratch marks may be underlain with thread-like petechial hemorrhages. Minute petechial hemorrhages may coexist independent of the scratch marks.

General inspection may also be designed to detect minor cutaneous vascular changes sequel to or attending intrahepatic vascular impairment. Since this involvement is insidious following minimal and moderate hepatocytic destruction, peripheral small blood changes may be evanescent and capillary changes evasive. These small peripheral vascular changes are most accurately evidenced in the picture of spider naevi.

The spider naevus is a small, cutaneous, arterial structure present especially on the face, neck, arms, fingers, upper torso and, less commonly, on the lower torso, thighs, and legs. Spider naevi are

telangiectatic bodies of various patterns and sizes. Some are evanescent but many have a permanently-formed central point with branching legs or spokes; veritably a sunburst of serpentine capillaries. A zone of erythema often encompasses the sunburst and may extend beyond it. Blood flow is from the central point towards the periphery.

These lesions may be insidious or rapid in development and may show slight pulsation confirmed best by cover glass pressure. Thus a rhythmic pulsation may be seen. Demonstrable spider naevi are said to be present in 74 per cent of moderately advanced cirrhotics and hence represents a diagnostic finding of great import in preascitic cirrhosis.[9] Infra-red radiation may elicit otherwise invisible naevi.[10]

An interesting phenomenon of peripheral circulatory disturbances is elicited in the so-called "liver-palms"—occasional symmetrical erythema due to capillary or arteriolar dilatation involving the eminences of the palms and digits of the hands (rarely the soles), at times extending over the fingertips to the nail beds and lateral distal phalanges, in all gradations from blotching to telangiectases.[11]

Larger blood vessel disturbances beyond the capillary size are observed in the malar regions and over the alar regions of the nose. The so-called bulbous, rosaceous nose is simply an extravagant picture of alar vascular distention. Even more pronounced collateral blood vessel distention, evidencing compensation between the portal and systemic circulations, are present on the chest and abdominal walls in about 25 per cent of cases. Prominence of these vessels is often seen on casual inspection.

A network of dilated blood vessels coursing upward over the surface of the abdomen and flanks extends generally to the level of the nipple but may extend to the supraclavicular region. Tortuous veins about the umbilicus are usually evidence of advanced portal cirrhosis, but may occur early and rapidly. In the recumbent position the dilatation disappears rapidly only to reappear rapidly on standing.

Intrahepatic blood vessel branches of the portal system show the greatest mechanical impairment by obliteration. Then urgent collateral circulatory changes appear at strategic anastomatic points between the portal and systemic circulations, as follows:

(1) Hemoptysis from lower esophageal varices.

(2) Hematemesis from engorgement of the left coronary vein near the cardia of the stomach.

(3) Umbilical and periumbilical venous engorgement in the embryonic vestigial accessory portal system of Sappey.

(4) The veins of Retzius which connect the portal veins with the intestinal and mesenteric veins and, in turn, the inferior vena cava and the retroperitoneal veins.

(5) Slight or massive rectal bleeding from collateral veins between the inferior mesenteric and superior hemorrhoidal plexuses.

Transient swelling of the ankles has been observed and has been variously interpreted as circulatory embarrassment or as evidence of hypoproteinemia.

Since insidious swelling of the abdomen often leads the patient to present himself for examination, a large liver may be found if the patient presents himself early and before the pre-atrophic stage has evolved. Once decrease in liver size has occurred, splenic enlargement may then be found but is often transient. Warm hands are essential for a good examination, and in a preliminary physical examination of the abdomen cold hands induce reflex muscle resistance.

The first palpation is often most informative, for if tenderness is present subsequent palpation causes voluntary resistance. Inability to palpate the liver or demonstrate decrease in liver size is suggestive of atrophic cirrhosis. In patients in the middle decades coexisting emphysema make inspiratory descent of the liver uncertain. Coexisting ascites make appraisal of liver size in many cases impossible. The position of the patient may be flat on the back or on the left side with the thighs flexed and abdominal wall as relaxed as possible. Loin pressure by the opposing hand may facilitate the examination.

Auscultation of the liver area may reveal a friction rub. Likewise, the stethoscope may reveal a venous hum in the periumbilical region, indicative of retrograde venous pressure.

Routine chest examination and particularly careful examination in the presence of impaired breathing and dyspnea may show basilar chest dullness and gross evidence of hydrothorax, unilateral or bilateral.

No examination is complete without inspection for herniae, either umbilical or inguinal. Rectal examination is a must and often reveals large, painless internal hemorrhoids.

Diagnosis

Findings in previous examinations are of extreme value. Gastro-intestinal upsets, varying from minor digestive upsets to hemorrhagic episodes, may have caused the patient to have had extensive physical examinations and x-ray studies. He may have had bronchoscopic and esophagoscopic studies and even gastroscopic examinations (although the latter two procedures are definitely contraindicated in known cases of cirrhosis).

Demonstration of esophageal varices, gastric vascular lesions, diminished liver size, and unex-

9. Bean, W. B.: The Cut. Art. Spider, *Medicine* 24: 243, 1945.
10. Jankelson, I. R. and Baker, Henry; Infra-Red Photog. of Abdominal Wall in Portal Cirrhosis of the Liver, *Am. J. Digest, Dis.* 5:414, 1938.
11. Perera, G.: A Note on Palmar Erythema (So-Called "Liver Palms," *J.A.M.A.* 119: 1417, 1942.

plained hydrothorax, increased splenic shadow, are highly pertinent findings, suggestive of cirrhosis.

Infra-red illumination and photography of the torso have been mentioned. Peritoneoscopy is of value and of minimum danger when performed by skilled technicians.

Liver biopsy is often most conclusive but here again technical procedure is not without danger and at present is not broadly applicable to general practice and out-patient observation.[12] The virtues of the transthoracic and trans-abdominal approaches are weighed. Liver biopsy should be undertaken only with adequate preparation to avoid hemorrhage.[13] Preparation consists of vitamin K orally and intramuscularly, and likewise a two liter reservoir of compatible blood, likewise from a donor prepared by vitamin K administration. X-ray examination in sequential manner has shown gradual shortening of the small and large bowel.[14]

Treatment

Obviously treatment is designed to alleviate or correct manifestations of the disease according to evidence of advance of the process of cirrhosis or of symptoms critical or otherwise.

Toxic-infectious factors, such as proctitis, sigmoiditis, colitis, infectious hepatitis, and biliary tract disease must be dealt with by eradication of infection and withdrawal of chemical agents inimical to adequate liver function and cellular regeneration. Withdrawal of contact from chemical agents (digestive, therapeutic, and industrial) is important and include alcohol, cincophen and derivatives, carbon tetrachloride, arsphenamine and sulfonamides.[15] Sulfonamides, en toto, are tolerated reasonably well by hepatotoxic patients despite the fact that acetylization and detoxifications of sulfonamides are supposed to occur in the liver. However, sulfonamides should be withdrawn in suspected cases of liver disease when toxic symptoms appear.

Use of morphine and strong barbiturates should be used with caution in alleviating distressing symptoms of cirrhotics. Initial doses are often innocuous but delayed cumulative actions appear rapidly with respiratory and circulatory depression.

Investigation of hemorrhagic lesions (varices) incur possibility of severe hemorrhage. Sclerosing treatment of varices has been successfully employed. Preparation of such patients should be designed to protect the patient from vascular injury by parenteral and oral administration of vitamin K.[16] Omentopexy has been successful in a limited number of cases. Treatment is practically designed to prevent irreversible liver damage or to partially correct existing liver damage.

Water balance is important not only to the ascitic cirrhotic but also to the pre-ascitic cirrhotic. A liberal intake of water is not detrimental to the patient and can be controlled reasonably by restriction of salt and, in extreme cases, sodium. The acid-base balance is important for alkaline bases retain water in the tissues. Acidification by ammonium chloride and, if necessary, mercurials, facilitates water excretion. Ammonium nitrate may be more effective than ammonium chloride. Salyrgan, mercupurin, and mercurhydrin may be used with reasonable safety.

Carbohydrate ingestion is important and simple. Periodic ingestion of sweets—candy, confections, et cetera, help to maintain energy. Encouragement of the cirrhotic to partake of ample carbohydrate and protein is most desirable.

Maintenance of nitrogen balance is important and when adequate protein cannot be taken, protein hydrolysates may be administered parenterally, or ordinary food tolerated poorly may be replaced by protein hydrolysates taken orally. Many varieties of powdered amino acids are on the pharmaceutical market. Intake of these substances assists greatly in sustaining the blood proteins, best evidenced by the serum-albumin-globulin ratio.

Human albumin may be administered in large doses, twice weekly. If human albumin is not available, human plasma may suffice, if given often and in large amounts, 500-750 cc.

Special diets are advantageous, with minimal fats (50 Gm.) and 125-150 Gm. protein, plus adequate carbohydrate to fulfill caloric requirements. Others state protein intakes up to 200 to 250 Gm. are requisites. When parenteral administration of protein hydrolysates are used, they should be supplemented by adjunct administration of the entire known essential vitamin agents.

Finally, choline, according to Best and Taylor,[17] aids in preventing cirrhosis; cystine prevents necrosis of hepatic cells due to its sulfur content. Casein does likewise. Methionine, one of the essential amino-acids, and a sulfur-containing element like cystine, accelerates the turn-over of phospholipids in the liver and kidney and prevents fatty infiltration resulting from hepatocellular degeneration. Lipotropic activity of choline, cystine, and methionine are the modus operandi in preventing liver degeneration.

Methionine is available in tablets 0.5 Gm., administered three or four times daily, with or without skimmed milk. This product is available through the Abbott Laboratories of North Chicago for investigational use by Federal Law. The results may prove to be encouraging.

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CIRRHOSIS OF THE LIVER: LABORATORY AIDS*

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THERE probably is no other entity in medicine that is recognized as readily as an advanced case of liver cirrhosis, and unfortunately when the diagnosis is made the only treatment possible is symptomatic. When the ascitic stage is encountered the damage is irreparable and the treatment is directed toward making the patient comfortable and waiting for the certain termination. It would therefore seem logical to attempt to recognize the disease in the first or preascitic stage when, with treatment, the cirrhosis can be controlled or even cured. As we are well aware, the clinical diagnosis of cirrhosis may be quite simple and obvious, as in the terminal stage, or it may be a difficult and many-sided problem in the early stages.

Certain features to be kept in mind in the diagnosis of hepatic cirrhosis are as follows:

(1) A careful history with reference to previous jaundice, alcoholism, and dietary deficiency, unexplained hematemesis and schistosomiasis.

(2) Physical findings of jaundice, pigmentation, hepatic facies and habitus, ascites and edema, enlarged or small liver, enlarged spleen, mental changes or coma, and

(3) Laboratory findings; that is, liver function tests and liver biopsy.

Although the pathogenesis is still obscure, most observers[1,2] agree that classic cirrhosis is essentially a chronic diffuse inflammatory process initiated by an obscure type of injury, followed by proliferation of connective tissue in and around former sites of degeneration and necrosis. This destruction of hepatic cells and replacement by fibrous tissue brings about a dysfunction of the liver processes and eventual changes in liver function tests. These tests, if used by the clinician, will aid in the diagnosis in the early stages.

The large number of procedures which have been proposed to evaluate the functional status of the liver clearly indicates that no single procedure is in itself entirely reliable or diagnostic. It would probably be unduly optimistic to anticipate a subsequent development of any single method which would regularly reveal the composite functional status of the liver. The innumerable functions of this organ, and the variable way that they may be impaired, would appear to be preclude the possibility of a "miracle" test.[3] The clinician must therefore choose, from the array of tests available, those best suited to a given case. Thus, in the presence of jaundice, the bromsulfalein test has relatively little value,[4] while it is often of the greatest help in seeking for evidence of liver disease in the nonjaundiced subject. Many of the tests, including the cephalin-cholesterol flocculation test, are actually not methods of measuring liver function, but rather of liver cell injury or irritation and when used must be evaluated as such. In the past several years certain groups[5] have been interested in correlating composite studies of liver function with the histology of the liver and the results have been gratifying enough to permit this statement, "The laboratory aids greatly in the early diagnosis of cirrhosis." The biopsy[6,7,8] procedure is likewise of proved value.

Jaundice in cirrhosis is of importance only as it focuses attention on the likelihood of liver disease. About 50 per cent of the cases of proved cirrhosis have at the time or give a history of a previous jaundiced state. In the nonjaundiced subject the following procedures have been suggested as the tests which will give the best possible index of liver injury:[9] the quantitative serum bilirubin; the hippuric acid synthesis; the fractional serum protein; the cephalin-cholesterol flocculation test; the bromsulfalein excretion test; and the quantitative urine urobilinogen test.

In the jaundiced patient this same group of

* Part II of a Symposium Presented Before the Indianapolis Medical Society, at Indianapolis, April 8, 1947.

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tests,[10,11] with the exception of the bromsulfalein, is employed, but with the addition of these—the serum cholesterol and alkaline phosphatase; the prothrombin time before and after vitamin K administration, and the feces urobilinogen test.

In the majority of these tests the technics used are those in common practice in clinical laboratories, and the use of a composite liver function study, with the results depicted in graphic form, has proved of considerable help in the analysis of hepatic disorders. This composite study has been given the name "hepatogram." With the normal values as the basic line, the laboratory results are charted below or above this line and a simple graph is obtained. The values departing above the mid-horizontal line indicate in general a diminishing liver function, while those departing below the line indicate either normal liver function or, in some instances, simple biliary obstruction with disturbance of function. By connecting the various values plotted one may obtain a "profile" of liver function for any given case.

Obviously, it is quite impracticable to employ the liver function study for purposes of "mass" screening, as for example in industries, in the armed forces, or in private practice, where financial means are limited or time doesn't permit all the tests to be accomplished. In these instances the following five procedures should be employed:

(1) Icteric index,
(2) Hippuric acid,
(3) Urine urobilinogen,
(4) Cephalin-cholesterol flocculation,
(5) Bromsulfalein.

The icteric index is essential to determine if jaundice does exist and to what degree. The test is a simple colorimeter test upon the serum or plasma.

The hippuric acid test [12,13] measures the ability of the liver to metabolize sodium benzoate to hippuric acid. It is performed by giving the patient 6 grams of sodium benzoate by mouth and measuring the hippuric acid excretion in the urine during the next 4 hours. The normal individual will excrete at least 3 grams of hippuric acid or more. In liver disease the amounts will be decreased.

The urine urobilinogen test depends upon the ability of the liver to re-excrete urobilinogen in the form of bile. When there is liver damage urobilinogen is not removed from the blood by the liver at the normal rate, and an excess appears in the urine. The normal amount is .5-1.5 milligram per day and the amount is proportionately increased in relation to the liver damage.

The cephalin - cholesterol flocculation depends upon whether the serum from patients will flocculate an emulsion made of sheep brain cephalin and cholesterol. Patients with active inflammation and disintegration of liver cells will show a marked flocculation whereas the normal serum will remain stable.

The bromsulfalein test measures the ability of the liver to remove a foreign substance from the blood. The test is of no value when the patient is jaundiced. Two milligrams per kilo of body weight of the dye is injected intravenously and determinations are made on the blood for its presence after 5 minutes, and again after 30 minutes. Values above 5 per cent retention in 30 minutes are abnormal and are roughly proportional to the severity of the liver damage. This test is most useful in detecting early stages of cirrhosis.

When any or all of the tests for liver function prove equivocal or if further confirmation is desired a diagnosis of hepatic cirrhosis may be established by liver biopsy. This procedure has been carried on for several years but it has recently been perfected and used extensively by such men as Hoffbauer, Evans, Watson[8] and Iverson.[7] The method consists of an aspiration technic through a posterolateral approach to the liver, the site of entrance being the ninth intercostal space in the right posterior axillary line. Infiltration of a local anesthetic agent is made at this site and skin punctured with a knife. A needle 18 centimeters long and 2 millimeters in width is inserted through the pleura and diaphragm and carried into the liver. The pointed obturator is removed and then by means of suction with a Record syringe a small plug of liver tissue is drawn up into the needle along with a few cc. of blood. This tissue can then be stained for histological examination. As a routine precaution the bleeding time, clotting time, and prothrombin time should be determined. The presence of any serious bleeding tendency is a contraindication. Likewise the presence of passive congestion of the liver or the presence of suspected hepatic abscesses is deemed a contraindication to needle biopsy.

In conclusion, may I state that the conjunction of the composite liver function study with liver biopsy has permitted much additional insight into the pathologic physiology of cirrhosis. It is recognized, however, that much experience must be gained before strict differentiation will be feasible on the basis of such studies and will never do more than supplement the history and physical examination in any given case.

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INTESTINAL OBSTRUCTION*

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THIS CONDITION continues to present a challenge to the physician and surgeon of today, since the mortality still remains between 30 and 50 per cent. In our attempts to lower this mortality we follow the teaching that the more certain the diagnosis the earlier the treatment and, hence, the lower the mortality.

Since bowel obstruction is a symptom complex and not a disease one hesitates to make a diagnosis of just "intestinal obstruction." It is with this in mind that we have attacked the problem in a little different way. To diagnose the condition properly we prefer to ask and answer four questions. These questions have been based upon the monumental works of Wangensteen, Haden, Orr, and many others. The questions proposed are the following:

(1) Is this an intestinal obstruction?
(2) Is it a large or small bowel obstruction?
(3) Is the obstruction complete or incomplete?
(4) Is it strangulated or non-strangulated?

In answer to *question number one*, "Is this an intestinal obstruction?" we expect to find the obstructive triad, namely, distention, obstipation, and vomiting. Although the triad may be present wholly or in part its individual parts call for clarification. In regard to *distention*, one must define what he means by the term. Realizing that we have no standard of measuring the distended abdomen we have decided to utilize the anatomic relationship of the umbilicus to the xiphoid process. We believe that the normal abdomen is scaphoid and not flat, hence, the umbilicus is normally placed below the xiphoid. When the umbilicus is on a level with the xiphoid, the abdomen is called *flat*, and when the umbilicus is above the xiphoid, the abdomen is described as being *distended*. Therefore, when the umbilicus is on a level with, or above the xiphoid, some pathologic condition exists. When such an abnormally placed umbilicus is found we consider the differential diagnosis of the seven "F's," namely, Fat, Feces, Fluid, Flatus, Fetus, Fibroids and "Ph"antom tumors. In almost every case one of these "F's" have been found to be the underlying cause. Therefore, it is important to record the position of the umbilicus when the patient enters the hospital, and re-check this every hour thereafter. If the umbilicus is below the xiphoid when the patient is first seen, and one hour later is found on a level with the xiphoid, this signifies early distention. In this way, we can avoid the development of a late preterminal distention that so many neglected intestinal obstructions present. Regarding *obstipation*, we know that the average patient with intestinal obstruction passes neither feces nor flatus, but we also recall that this may be lacking in incomplete obstruction, as for example in Richter's hernia, in which only part of the circumference of the bowel is incarcerated. In such cases the resulting irritation and hyperperistalsis may even lead to a diarrhea which can be most annoying when one makes a diagnosis of intestinal obstruction. *Vomiting* will be more thoroughly discussed under question number two. Regardless of the absence or presence of the obstructive triad, it is far more important to elicit the one pathognomonic finding of intestinal obstruction, namely, that *pain and intestinal sounds appear at the same time.* It is this synchronization of sound with pain that differentiates intestinal colic from any other type of intermittent pain. When the patient states that he is getting his pain, the physician should place his stethoscope upon the abdomen, and if the pain is of an intestinal nature, he will hear the rushing bowel sounds at this time.

Question number two, namely, "Is this a large or small bowel obstruction?" The most important differentiating factor to this question is whether or not vomiting is present or absent. Patients with large bowel obstructions do not vomit, but those with small bowel obstructions do. We all have seen late cases of large bowel obstruction where vomiting has been present as a late and not too distressing symptom, but in the small bowel lesions vomiting appears very early. We further know that the higher the obstruction the more fulminating the vomiting. Based on this one fact, we can usually differentiate the small from the large bowel obstructions. To use the word "fecal" vomiting as being descriptive of intestinal obstruction is incorrect. The term "feculent" is more descriptive, since fecal vomiting refers to a gastrocolic fistula or some similar lesion. To further differentiate the small from the large bowel obstruction we utilize the flat x-ray plate. It is unnecessary to have the patient stand or turn or give him any contrast media. A flat x-ray picture, which can be taken with a portable machine, will usually give the desired information. If the obstruction is caused by a large bowel lesion the x-ray plate usually reveals a large, distended colon which appears as a horseshoe or inverted "U." The most common location for such lesions is the rectosigmoid. If,

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on the other hand, the obstruction is small bowel in nature, the typical paralleling or stepladder pattern will be present. The history also aids in differentiating the two types of obstructions. Hence, a slow, progressive, chronic, increasing constipation indicates a large bowel lesion, but a sudden, violent attack signifies small bowel pathology. Patients with intestinal obstruction who have had previous surgery are small bowel obstructions until proved otherwise. The large bowel obstruction resulting from postoperative adhesions is a rarity. A two-quart diagnostic enema is also of help. The large bowel can usually retain two quarts of fluid plus its usual contents. If the bowel cannot take the two quarts, this speaks for a large bowel lesion. There are many other ways of differentiating the two, but time nor space does not permit extending this discussion.

Question number three states, "Is this a complete or incomplete obstruction?" As has been mentioned, a patient with a complete intestinal obstruction passes neither flatus nor feces per rectum, but if the obstruction is incomplete, some flatus and feces may be expelled, especially with repeated enemas. It is important not to be misled by the results of the first enema, since a copious movement and flatus may be expelled following its administration. This, however, is material which is distal to the lesion. If repeated enemas bring flatus and feces, then we assume that the obstruction is incomplete; if the returns of the repeated washings are clear, we conclude that the obstruction is a complete one. It is wise to take a "scout" film of the abdomen when the patient arrives. This immediately reveals the bowel pattern and also determines whether or not flatus is present in the region of the hollow of the sacrum. If the flatus over the sacrum is absent following repeated enemas we consider the condition a complete obstruction, but if flatus continues to come down and appears over the sacral region the lesion is an incomplete one. A patient with a complete obstruction will appear more ill than one with an incomplete lesion, therefore the clinical appearance and impression is of importance.

Question number four, "Is this a strangulated or non-strangulated intestinal obstruction?" can usually be answered by the presence or absence of *tenderness*. Patients with intestinal obstructions do complain of colicky pain, but only when strangulation is present is there pain plus localized tenderness. This tenderness is best found by the patient, who will usually locate the exact point of the pathology. The classical example of this is a strangulated inguinal hernia. The patient has diffuse pain over his entire abdomen, but will permit one to palpate it, however he resents having pressure made over a strangulated mass because of its exquisite tenderness. Our incision is usually determined by the location of the patient's tenderness. Another differentiating point between the strangulated and non-strangulated obstruction is the appearance of the patient. A patient who has a strangulated intestinal obstruction is acutely and violently ill and ofttimes in shock or impending shock, whereas the patient with an intestinal obstruction without strangulation does not present such a dramatic picture. The flat x-ray plate may aid in the differentiation of a strangulated and a non-strangulated, small bowel obstruction. If a small bowel, non-strangulated intestinal obstruction is present, the typical stepladder pattern is observed and the valvulae conniventes are readily seen. If, on the other hand, a small bowel, strangulated obstruction is present, no characteristic bowel pattern is assumed since the distended loops arrange themselves in whatever portion of the abdomen the obstruction occurs. The valvulae conniventes are not easily detected or seen because of the extravasation of blood into the strangulated loop of bowel and into the abdominal cavity.

Based on these four questions, one may make a proper diagnosis instead of just "intestinal obstruction." The case, therefore, may be diagnosed as a large bowel, non-strangulated, incomplete intestinal obstruction, or a strangulated, small bowel, complete intestinal obstruction, depending upon the findings. When a diagnosis is made this way one immediately comprehends the problem, and the treatment automatically presents itself.

Treatment

The treatment of intestinal obstruction is difficult to understand if one labors through the voluminous literature on the subject. It is wise, therefore, to have a plan based on a simple summary. The plan that I have devised is based on the five "S's," since we state that the treatment of intestinal obstruction consists of Suction, Saline, Sanguine, Surgery, and Sulfa.

Suction, or gastro-intestinal siphonage, has done much to lower the mortality of this condition. It has its pitfalls, however, and these must be kept in mind. It has no place in large bowel obstructions nor should it be used when strangulation is present. On the other hand, it may be curative in postoperative ileus, non-strangulated adhesive obstruction, or in obstruction associated with peritonitis; these are usually small bowel lesions. Its value as a pre- or postoperative adjunct needs no emphasis. To keep a patient with a carcinoma of the rectosigmoid and a large bowel intestinal obstruction on continuous siphonage is to court disaster; hence, its uses and abuses must be thoroughly understood.

Saline can prolong the life of a patient with an intestinal obstruction, however it cannot cure the condition. It is an excellent form of supportive therapy. In a patient who has manifested a great deal of vomiting, or in whom continuous gastro-intestinal siphonage has been instituted, chloride ions have been lost. These must be replaced, and it is mainly by the use of physiological saline that the patient's chloride balance may be maintained. It is by restoring this electrolyte balance that one

is able to put his patient into better condition to withstand surgery, and in this way to lower the mortality. Saline, however, is not the only supportive therapy the patient needs; this will be discussed subsequently.

Sanguine is the word used to refer to blood and its derivatives. We feel that the only place for the use of whole blood is in the replacement of lost red cells. We prefer to keep the protein balance of the patient normal with plasma, serum, or amino acid therapy. If the obstruction is associated with blood loss, we feel that the fluid of choice is then whole blood. In many cases of strangulated obstructions, or in cases which might necessitate extensive bowel resection, whole blood is preferred. Maintaining a normal protein level permits a patient to properly seal because of his good fibrin content. Two things which must be avoided in the case of intestinal obstruction, as well as all other surgical emergencies, are hypoproteinemia and hyperchloremia. Too little protein and too much chloride both produce tissue edema and permit the patient to "drown" in his own body juices. It is because of hypoproteinemia and hyperchloremia that sutures pull out of edematous tissue. It is not the result of faulty suturing or material that causes intestinal leaks to occur, but rather to poor pre- and postoperative care. The patient's vitamin needs must be maintained, especially the water soluble vitamins B and C which he loses readily. Vitamin C is truly the "surgeon's vitamin," because this is the one which is essential to sound wound healing.

Surgery is a subject which cannot be discussed adequately in a few pages, and I will only touch upon the surgical highlights as they pertain to the patient with an obstruction. If a patient has a strangulation he should have immediate surgery. As has been stated, the patient will tell us where to make the incision if we permit him to reveal his most tender spot. Complete large bowel, nonstrangulated lesions require immediate colostomy for the release of intracolonic pressure. We prefer the so-called "blind cecostomy" in such conditions. This is made through an exaggerated McBurney's incision which hugs the anterior superior iliac spine. If the cecum is distended, and it surely should be in an obstructed colon, then it bulges into the wound. It is held in place by two hemostats and an iodoform pack is placed between the cecum and parietal peritoneum. Following this stitchless procedure, the patient is returned to bed and the cecum is opened some six hours later, after it has had a chance to seal off. It is unwise to attack an obstructed colonic lesion directly, since the bowel wall is edematous and will not retain sutures. It is for this reason that we leave the primary pathology alone and do a preliminary cecostomy. For the following ten days or two weeks the patient may be deflated, prepared, and then re-operated. It is at such a time that a true evaluation of the pathology can be made and a resection done. The cecostomy acts as a vent in the event that an intestinal anastomosis is performed. In strangulated lesions we may be confronted with the question, "Is the bowel which has been freed viable or not?" It seems impractical to stand about placing hot towels on a segment of intestine and watch its color. Viability is readily determined if one merely flicks the bowel with the finger and watches for peristaltic waves. Regardless of the color of the intestine, if it is able to contract it is viable. Intestinal obstruction is usually associated with a transudate which is present in the peritoneal cavity. If this transudate is bloody then a strangulation is present. Therefore, if a blind cecostomy is done and a sanguineous fluid noted we must abandon the cecostomy and explore for the presence of a strangulated lesion. The type of anastomosis performed is purely a personal one, however we feel that a lateral anastomosis is safest in the hands of the occasional operator. If time is a factor one should be familiar with the technic of the so-called quick, "aseptic," end-to-end anastomosis.

Sulfa drugs have taken their place among the chemotherapeutic agents used in the treatment of intestinal obstruction. There is also a place for such allied drugs as penicillin and streptomycin. Following the surgery, we place three to four grams of sulfathiazole or sulfadiazine in the peritoneal cavity and follow this with forty thousand units of penicillin every three or four hours intramuscularly. We do know that penicillin will not affect the colon group of organisms but it will attack streptococci and staphylococci. Sulfadiazine is administered intravenously following the first postoperative day and streptomycin is coming into its own as the main chemotherapeutic agent against the gram negative rods. Sulfasuxidine and sulfathaladine will keep the bacterial count low in the intestinal tract if these drugs can be taken by mouth.

Only the surface has been scratched in this discussion of the vast subject of intestinal obstruction, however we feel that if we approach the problem with the "Four Questions," make a diagnosis based upon these, and then summarize the treatment with our "Five S's," we should have a logical approach to a given case.

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THE ADMISSION CHEST SURVEY IN A GENERAL HOSPITAL PRELIMINARY REPORT*

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THE merit of the routine admission chest roentgenogram has been well established in the relatively brief period of its use. In the hands of the United States Public Health Service, armed forces, tuberculosis associations, Selective Service, and in numerous tax-supported hospitals it has been of tremendous importance in the detection of abnormalities of the heart, lungs, pleura, or the supporting bony thoracic cage. It has been estimated that from 8 to 22 per cent of all general hospital or clinic patients show disease on routine roentgenograms of the chest. Urinalysis, blood counts, and the serologic test for syphilis long have been established as routine hospital admission procedures, yet the incidence of pathological findings in chest surveys is greater than the incidence of significant abnormalities detected by these procedures. The importance of the early recognition of pulmonary tuberculosis by photofluorography cannot be overestimated. The existence of primary carcinoma of the lung may be detected in its early, curable stage, although a differential diagnosis by this method alone may be impossible. The presence of cardiac and aortic abnormalities is equally susceptible to detection. The wider use of the survey method may well prove a boon to the cardiologist in the detection of the early stages of cardiac lesions which steadily assume a more important role in the mortality statistics.

The hospital is an ideal place for a routine chest roentgenographic survey and it seemed to me that such a study in a large volunteer hospital such as the Methodist Hospital of Indianapolis would be of tremendous importance in promoting the welfare of the community. With over 20,000 in-patients admitted annually, this hospital seemed to offer an ideal proving ground to determine the incidence of chest pathology in the middle and upper strata of central Indiana citizens.

With some timidity I asked Dr. Hilleboe, then Chief of Tuberculosis Control of the United States Public Health Service, if it might be possible to borrow a government-owned unit for photofluorographic survey purposes. I was delighted when he was not only willing but enthusiastic over such a survey. As soon as an x-ray unit used by the Indiana State Board of Health became available it was installed in the hospital. The whole-hearted co-operation of Drs. Burney and Bundy of the Board of Health in providing this equipment, personnel, and advice has been greatly appreciated.

When the survey was started I had no idea of the difficulties that might arise in securing examination of a high percentage of hospital in-patients. At Ann Arbor Dr. Fred Hodges has been able to examine 85 per cent of the hospital admissions. True, this unit is in the Registration Department and he works in a state-owned-and-operated, not a volunteer hospital, but I thought it should be possible to examine approximately that percentage of our hospital patients. Until the present we have been surprised and greatly dismayed at the small proportion of patients we have been able to examine in our survey, but I reckoned without several factors; for one thing, the tonsillectomy patients, a large group, enter the hospital at seven o'clock and are operated upon at eight or nine o'clock the same morning, so we miss the majority of them because they leave before seven o'clock the following morning.

When the obstetrical patients are admitted, delivery is usually so imminent that any extra exertion must be avoided. Present conditions make it necessary to limit the hospital stay of these patients to five days and the obstetricians are loath to permit their patients to sit up for a roentgenogram so early or to permit their possible exposure to contagious or infectious diseases. These large groups, added to the group of seriously ill patients we had expected to miss, have lowered to 37 per cent the proportion of the hospital patients we have been able to examine. In the case of the obstetrical patients we believe we have solved the problem by a plan worked out with the members of the Obstetrical Service. Those patients likely to be confined in the Methodist Hospital are referred for an examination as early in the prenatal period as possible. They and the obstetricians have been delighted with this plan which permits us to examine this particularly important group. Thus far we have been unable to completely solve the other problems but will continue to work in this direction.

That aspect of the survey which has dismayed me most has been the apathy of some attending physicians in the face of positive survey findings and advice to have further radiological study of their patients. It is true that we have confirmed with 14 x 17 films the presence of active pulmonary tuberculosis in only a small number of patients. However, very few in-patient re-examinations were negative. A number revealed fibroid

* Read at a meeting of the Indiana State and County Anti-tuberculosis Committees and the Indiana Chapter of the American College of Chest Physicians, October 30, 1946, and at a meeting of the Indianapolis Medical Society, January 21, 1947.

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and calcified tuberculosis which, though apparently inactive, is certainly clinically significant, and about an equal number revealed cardiac enlargement. Other pathological findings varied from pneumonia to lung abscess. There were three instances of hydrothorax and three of bronchiectasis. A survey is as valuable as the follow-up on its findings. The radiographic follow-up is certainly not as poor as might appear when I say that only 22 per cent of the patients in whom further study was requested had 14 x 17 radiographic examination in this department. There are extenuating circumstances: the duration of the patients' hospital stay has often been short; with our present method the report on the survey film findings does not get to the patient's chart in less than 24 hours after exposure and sometimes there is a delay of 72 hours. Fundamentally the attending physicians are co-operative, but it will take six months to a year or more to educate them in the mechanism of the method and to awaken them fully to its great value.

Since August 12, 1946, we have had an accurate study of 981 employee examinations. Of this group 138, or 14.1 per cent, were shown to have pathological processes which were of insufficient clinical importance to demand further radiographic study. The findings in 77, or 7.8 per cent, were believed to justify more complete examination. Exudative pulmonary tuberculosis was found in the 14 x 17 radiograph of only one person, but there were 17 other instances of pulmonary tuberculosis, chiefly of the fibroid and calcified type, probably inactive. Ninety-seven persons had enlarged hearts, and there was evidence of aortic arteriosclerosis in a similar number. Non-tuberculous pulmonary infiltrations of various types were found in 44 instances.

As had been expected, the incidence of significant abnormalities of the chest is considerably greater in 3,177 hospital in-patients, 358, or 11.3 per cent of whom presented departures from the normal insufficient in magnitude to justify a request for further radiographic study. Four hundred and nine, or 13 per cent of this group had pulmonary lesions which should have been checked by 14 x 17 radiographic study; of this group only 22 per cent were so studied. The most frequent variation from the normal was cardiac enlargement, which per se was not considered to necessitate further study. This was found in 388, or 12.2 per cent of the patients, and evidence of aortic arteriosclerosis was found in 343, or 10.7 per cent. A questionable pulmonary lesion was found in 305, or 9.5 per cent, and a definite pulmonary lesion, usually considered to be tuberculous, was found in 102, or 3.3 per cent. There were 19 instances of hydrothorax, and pleural adhesions were demonstrated 54 times. There were 31 instances of mediastinal widening, probably due to substernal goiter. Tracheobronchial lymph node calcification was present in 40 per cent of this group and in 43 per cent of the employees.

Four hundred sixty-two prenatal chest examinations have been made since this procedure was started, though 201 examinations were made in the first two weeks. The decrease in number of examinations is due largely, I suppose, to the fact that we have found no significant lesions in a majority of those examined, and there is little incentive. Only four instances were found of lesions suggestive of tuberculosis, and none of these has been found on further study to be an active lesion. The heart shadow appeared to be abnormal in 11, but this was due largely to the elevation of the diaphragm. Other findings were of no clinical significance.

In the development of a form on which to report the findings of the admission chest roentgenogram I copied almost verbatim the report of Dr. Fred Hodges of Ann Arbor, to whom I am indebted for advice and counsel. Some of these reports have been printed separately for use in the prenatal group and the employees. For in-patients this sheet has been incorporated in the admission registration form, and the pertinent data such as name, address, age, sex, race, name of physician, and room numbers are automatically recorded when the admittance record is typed. The "Report of Admission Chest Roentgenogram" is brought to the X-ray Department with ambulatory patients and is left there. In the case of ambulance patients and those who register when the X-ray Department is closed, this form goes to the chart room of the floor to which the patient is sent. When the patient's condition is such that he can be brought to the survey unit on a litter, the "Report of Admission Chest Roentgenogram" is initialed by the physician, resident, or an intern and is sent to the X-ray Department as a requisition. The patient is then brought to the department as soon as possible. The film roll is removed at noon each day with the exception of Friday, when it is removed in the evening. During the week each role of film removed includes roentgenograms of patients examined from noon one day until noon the next. The film inserted on Friday evening is removed Monday noon and consequently the report of the examinations done over the week-end is somewhat delayed. When the films are interpreted, usually three hours after their removal from the camera, the reports are sent to the Record Division where the results are tabulated and from whence the reports are sent to the floor.

When, during the late war, an industrial physician told me that his preemployment 14 x 17 radiographic examinations of the chest were made without having the patients undress, I was deeply shocked. The shock was only slightly less when Dr. Hilleboe assured us that for survey purposes it is unnecessary to have the patient disrobe. Subsequently, in the examination of miniature films of fully clothed patients submitted for interpretation by the Marion County and the Indiana Tuberculosis Association, I found that shadows cast by

clothing are not confusing in the vast majority of the cases. One quickly learns to ignore radio-opaque buttons, clips, and similar shadows and they do not sufficiently obscure the lung fields to present diagnostic difficulties.

Conclusions: In a routine chest survey in a large general hospital, using the 35 mm. film method, it has been found that:

1. It has been difficult to secure examination of a large proportion of in-patients with a unit located some distance from the admittance department.
2. It is difficult to secure 14 x 17 radiographic examination of the positive cases.
3. The examination of hospital employees is easily accomplished and significant lesions were found in 7.8 per cent.
4. The incidence of significant chest lesions among hospital in-patients is half again as great as that found in the employee group.
5. Exudative pulmonary tuberculosis has been an infrequent finding but fibroid tuberculous lesions were found in 1.7 per cent of the employees and in 3.3 per cent of the in-patients.
6. Demonstration of cardiac abnormalities by this method is of great importance.
7. Accurate examination can be secured without having the patient disrobe.

EAR, NOSE, AND THROAT OFFICE PRACTICE FOR THE GENERAL PRACTITIONER

Fred McK. Ruby, M.D.

UNION CITY

(*Editor's Note:* Doctor Ruby had announced the limitation of his practice to the eye, and his fellow members requested him to address them on some of the more common diseases of the ear, nose, and throat.)

In discussing some office procedures in ear, nose, and throat practice, I shall proceed with an examination and develop the treatment as I go along. Except as I shall call your attention to irregularities or anomalies, I shall take it for granted that you are familiar with the gross anatomy. I can not make specialists of you—even those of you who have practiced for sometime—but I can try to point out procedures for relief of certain symptoms.

First, let us consider the mouth and throat; the first complaint is "Sore Throat." If the tonsils or pillars are reddened, especially if they are swollen, and the posterior wall of the pharynx is fairly smooth and not dry, the case can be treated, locally, as follows: cleanse the area with hydrogen peroxide, on cotton, or use an alkaline, hot gargle. Follow this with a light massaging of the tonsil area with a cotton swab saturated with tincture of metaphen. The relief is almost magical. If the mouth shows cankered ulceration, sulfa solution or alkaline washes are beneficial. The patient, if nervous, rarely has a hydrochloric acid deficiency in digestion, with fermentation acid in the mouth. Then, 10 minim doses of dilute HCl., in adequate water, at each meal, often gives surprising results. The same holds true for food allergies. Acidulin pulvules, or Dil. HCl. solution often proves helpful. (Supportive treatment in all these cases should be well known and is omitted.)

Pharyngitis. If the sore throat shows pillars and tonsils are not greatly involved, but the posterior pharyngeal wall is very red, hot, and dry, the preceding treatment is useless. The gargle does not reach the site of the inflammation. Hence, a hot drink, or warm saline down through the nose to the pharynx, followed either by bland oil through the nose, or weak iodine solution in oil or glycerin to the pharynx, on cotton, will give relief. Etiologically, most of these cases have their origin in the sinuses, and this source of trouble must be considered.

Trachea. Where the trachea and bronchi are involved, especially when there is a dry, hot appearance, the aforementioned oil, warm, in the trachea, by long dropper in the mouth, or by a curved syringe, will help. And may I say here that in forty years of a practice which covered most of our district, I have seen but one case with residual oil in the bronchioles, and even in that instance the patient was much better off than before.

Nose. Most patients with sinus disorders have either heavy discharge, blocked breathing (transient or chronic), or pain in and around the head. As to the latter, when the nose is at fault, the diagnosis is aided by finding the pain worse when the head is down, as in tying the shoe. Examination will show one of a number of things. Acute sinuses require little but a shrinkage of the nasal tissues to allow drainage and aeration of sinuses. This can be aided by posture or by mild suction. No salt solution should be used in the nose for anything except a chronic dry nose, with crusting. In all other cases, the protective mucus, as well as the infection, is removed by saline, and leaves the nasal tissues exposed to dust and further infection. In chronic cases sinus openings may have

to be freed by mechanical means, in which case the patient should be referred to a specialist. In dripping noses, especially posterior, allergy should be suspected, and efforts made to find the cause, whether air-borne, contact, or food allergy.

"*Dry Nose.*" When the nose is crusted, with greenish-tinged crusts, and possibly there is also rubbery mucoid material in the upper pharynx, the occasional clearing of the nose with a warm saline solution, (used with but little force), should be followed by one of three treatments: (1) massaging of the septum and turbinates gently with 1 per cent iodine in glycerin; (2) spraying with amniotic fluid; or (3) packing with iodized oil. The continuous use of iodized oil (1 per cent), at least two times daily by the patient, with the oil going well up and back into the nasopharynx, will assist in relieving a very uncomfortable and annoying condition. (Note statement above as to use of oil in head and throat.)

Pain in the head, especially if referable back from one frontal area to the base of the skull, on the same side, and even to the shoulder or arm, same side, but unaccompanied by any evidence of pus in sinuses, will very often be a pressure symptom, and may be relieved by an anesthetic and a decongestant to the anterior tip of the middle turbinate, same side. Rarely is it necessary to fracture a tightly pressing anterior tip by a cotton tipped rigid applicator. The results are often miraculous.

Ear. Lastly, the ears. Complaints are pain, deafness, and ringing noises. Pain, if accompanied by tenderness over sternocleidomastoid muscle, usually indicates involvement of the tube and middle ear. If the pain is in front of the ear, the trouble is usually in the canal; it then hurts to chew. If the pain is over the mastoid, and there is fever and the ear is red, that is a case for a specialist. If the tenderness is matched by tenderness of Ewing's point and there is no fever, the mastoid pain is usually a referred pain. In deafness the canal should be examined for cerumen, and the drum examined for retraction and color. Ringing and noises are also referable to a specialist. The prognosis for relief is usually poor.

In external otitis, or pain in the canal, the canal should be cleansed, again with peroxide on a cotton applicator, wiped dry, and then packed with a ⅜-inch gauze strip saturated with rubbing alcohol or salusol (an acetic ether compound). If there is itching, use alcohol, and then swab with plain vaseline or carbolyzed vaseline to soften the skin.

Much has been omitted, which would only tend to cloud the diagnosis and treatment. However, these simple procedures may be helpful to your patients, as well as to yourselves.

TULAREMIA IN INDIANA INCLUDING A REPORTED INDUSTRIAL OUTBREAK*

James W. Jackson, M.D.†

INDIANAPOLIS

THE FIRST PROOF of a reservoir of infection of tularemia in Indiana was in 1914. At that time Dr. William B. Wherry and his associate, B. H. Lamb, were working in the laboratory of the Cincinnati General Hospital. They learned that rabbits were dying in large numbers in the neighborhood of Vevay, Switzerland County, Indiana. Investigators picked up two of these and shot three others. The dead rabbits were found to be infected with Bacterium tularense.[1] The disease, as judged by reported cases and deaths, is distributed rather uniformly over all of Indiana.

Geographical Distribution

Map I** depicts the geographical distribution, the morbidity, and mortality of tularemia in Indiana during the interval 1928 to 1945, inclusive. The numbers representing the deaths are circled. Either cases or deaths have been reported from all but five of Indiana's ninety-two counties. Those not reporting either cases or deaths are Blackford, Tipton, Clinton, Crawford, and Martin counties, 5.4 per cent of the political subdivisions of the state. Clark County and Delaware County reported mortality but no morbidity. During the eighteen years covered by the survey a total of six hundred and sixteen cases and seventy-one deaths were reported. Hence, the case death rate appears to be 11.5 per cent. This death rate is

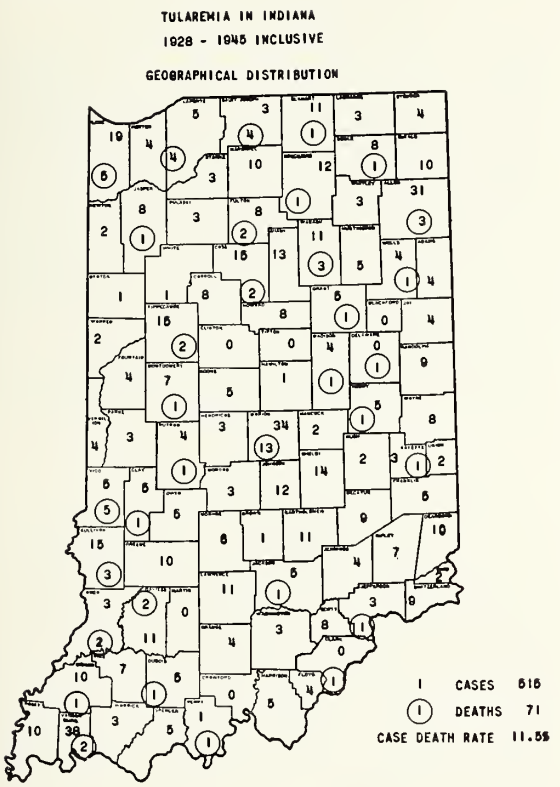
* Presented at the Seventh-fourth Annual Meeting of the A.P.H.A. before the Epidemiology Section, Third Session, Club Room A, Auditorium, Thursday, November 14, 1946.

† Director, Division of Communicable Disease Control, Indiana State Board of Health.

1. Wherry, William B. and Lamb, B. H.: Discovery of Bacterium Tularense in Wild Rabbits and the Danger of its Transfer to Man, *J.A.M.A.* 63:2041, December 5, 1914.

** All charts, maps and tables were prepared under the critical supervision of Mr. R. E. Serfling, Director of the Division of Statistical Research with the technical assistance of Mr. Bird Baldwin, Department of Health and Physical Education, Indiana State Board of Health

obviously incorrect. It is more likely that it is about 7.2 per cent as reported by Edward Francis.[2,3]



Age Distribution

Chart I reveals the age distribution of tularemia for males and females combined for one hundred and two laboratory positive cases of tularemia.

Chart I
Tularemia in Indiana 1942--1946

Age Group	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-85
Total Cases	6	12	16	24	28	7	8	1
Male	5	8	11	18	13	5	4	1
Female	1	4	5	6	15	2	4	0

In this chart the age distribution of Tularemia is shown for males and females combined, for 102 laboratory positive cases.

Reported cases include individuals from five to eighty-five years of age. Six cases were reported in the group five to fourteen years of age. One case occurred in the group between seventy-five to eighty-five years of age. The highest incidence, twenty-eight cases, was in the group forty-five to fifty-four years of age.

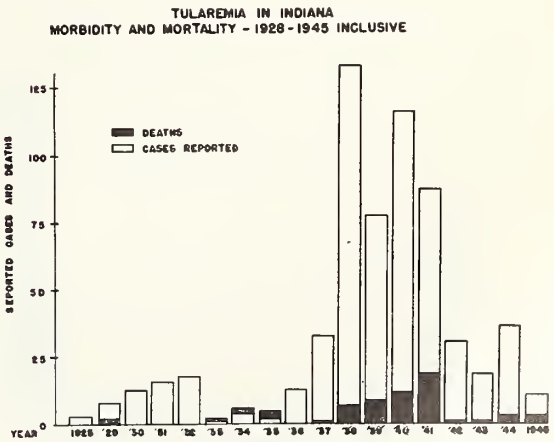
Morbidity and Mortality

Chart II portrays cases and deaths by years for the interval 1928 to 1945 inclusive. Unshaded portions of the bar diagram represent cases; shaded portions indicate deaths. These are shown on the chart from left to right as follows:

Year	*Cases*	*Deaths*	
1928	3	0	
1929	8	2	
1930	13	0	
1931	16	0	
1932	18	0	
1933	1	2	
1934	4	6	
1935	2	5	
1936	13	0	
1937	33	1	
1938	134	7	
1939	78	9	
1940	117	12	
1941	88	19	
1942	21	1	
1943	19	1	
1944	37	3	
1945	11	3	
	616	71	11.5

It is obvious the case death rate of 11.5 is incorrect, for in each of the years 1933, 1934, and 1935, more deaths than cases were reported. However, the data does seem to support the thesis that the disease has a tendency to appear in cycles. The low incidence up to 1937, the high incidence during 1938, 1939, and 1940, followed by another low incidence, suggests corresponding fluctuations in the animal reservoir.

The graph also clearly discloses the status of reporting, showing the usual tendency toward better reporting during outbreaks.



2. Francis, Edward: Tularemia, A Broadcast over the A.B.C. Network, November 20, 1945, Lederle Laboratories Inc., 30 Rockefeller Plaza, New York 20, N. Y.
3. Illinois State Dept. Health, Ed. Bull. No. 44, 1932.

Seasonal Incidence

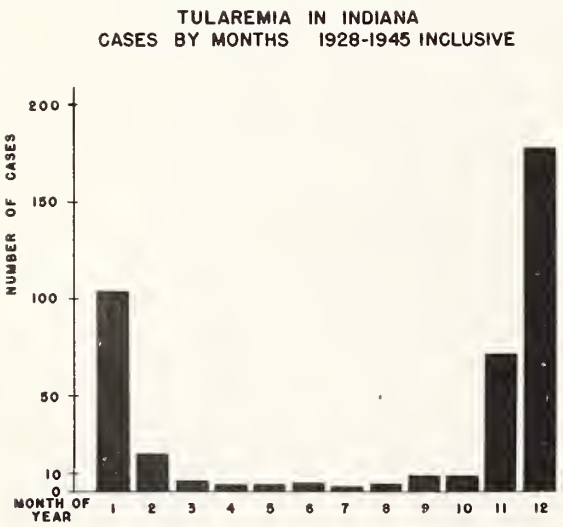
Chart III discloses that tularemia may occur during any month. The graph compares the incidence by months and years for the interval 1928 to 1945, inclusive. Each year the number of reported cases begins to increase in November, rises to a peak in December, and falls to its previous level in February. Reading the diagram from left to right, we note in the month of:

Reported Cases

January	104
February	20
March	6
April	4
May	4
June	5
July	3
August	4
September	9
October	9
November	71
December	377
	616

The major relation between incidence and season appears to be a legislative act making the hunting of the rabbit legal from November 10 to January 10. During this seasonal interval, November, December, and January, five hundred fifty-two cases were reported, as compared with sixty-four during the rest of the year. Of the sixty-four transmitted by a vector other than the rabbit some were due to ticks. In Indiana the most prevalent tick is Dermacentor variabilis. It feeds on the blood of dogs, rabbits, mice, cattle, horses, and many other animals, and man. It has been found to transmit the disease from May to mid-August.

Chrysops discalis, the horse fly, may also transmit the disease during June, July, August, and September. It feeds on horses, cattle, rabbits, and man.[4]



Analysis of Cases by Type of Diagnosis

Table I is an analysis of one hundred and twenty-three cases of tularemia by type of diagnosis, sex, and age. Section I of the table includes the cases in which both laboratory and clinical findings were helpful in diagnosis. These data were available and were utilized in one hundred and two of the one hundred and twenty-three cases.

Section II of Table I shows that negative laboratory findings were associated with the diagnosis of clinical symptoms in only eight of one hundred and twenty-three cases.

Section III reveals the physician was satisfied with clinical findings alone in eighteen (14.6 per cent) of one hundred and twenty-three diagnoses.

Table I
Analysis of 123 Reported Cases of Tularemia by Type of Diagnosis, Sex and Age
Indiana
1942-1946

Type of Diagnosis		Age Group								Total	Total Male Female
		5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-85		
Positive Laboratory Positive Clinical	M	5	8	11	18	13	5	4	1	65	102
	F	1	4	5	6	15	2	4		37	
Negative Laboratory Positive Clinical	M			5	1					6	8
	F				1	1				2	
Clinical Only	M	1		1	2	3	1			8	18
	F			1	2	1	1			5	
Total	M	6	8	17	21	16	6	4	1	79	123
	F	1	4	6	9	17	3	4		44	

This table shows the distribution of cases by age and by sex and type of diagnosis. The differences in age distribution for males and females are not significant.

Analysis of One Hundred and Twenty-Three Cases of Tularemia by Source and Method of Diagnosis

Table II is an analysis of tularemia according to reported sources of infection by method of diagnosis. Reported sources include mammals in one hundred and seventeen instances. Of these, the reported source was the rabbit in one hundred and eight persons, including: ninety-one in whom the diagnosis was based on clinically positive laboratory evidence; eight with clinically positive, but negative laboratory findings; and nine with clinically positive evidence only.

The squirrel was supposed to have been the source of infection in three cases in which both laboratory and clinical evidence were positive, and in two instances with clinically positive evidence only.

Clinical and laboratory evidence implicates the muskrat in two instances, the opossum in one, and the cat in one.

Infection from the opossum was believed to have been transmitted by cutting a finger while dress-

4. Francis, Edward: Sources of Infection and Seasonal Incidence in Man, Reprint No. 1799, from the Pub. Health Reports, 52:103-113, January 22, 1947.

Table II

Analysis of 123 Cases of Tularemia According to Reported Source of Infection by Method of Diagnosis

	Reported Source of Infection	Diagnosis: Clinically positive Laboratory	Clinically positive Laboratory Negative	Clinical Only	Total
MAMMAL	Rabbit	91	8	9	108
	Squirrel	3		2	5
	Muskrat	2			2
	Opossum	1			1
	Cat	1			1
BIRD	Pheasant	1			1
ARTHROPOD	Tick	3		1	4
	Sweat Bee			1	1
		102	8	13	123

In this table reported source of infection is shown by type of diagnosis.

ing the carcass. One woman was bitten by a sick cat. Three weeks later chills, fever, malaise, and headache developed. Serology was positive in a dilution of 1:40.

Dr. Ralph B. Williams says: "The muskrat has been associated with human infections only in Oregon, Idaho, Montana, New York State, and at Northway on the upper Tanana River Drainage, Alaska."[5] Now Indiana may be included in the lists of those areas where the muskrat is a reservoir of B. tularense.

During the interval of the study the pheasant was the only bird alleged to be responsible for a case of tularemia in man in Indiana. The diagnosis was made with the aid of positive laboratory results and significant clinical findings.

Arthropods were believed to be the vectors in five instances. The tick was the reported source of four of the cases. Dr. M. G. M. reported that C. D. was infected in the eye by blood from wood ticks which he crushed in the process of removing from beagles.

Three of the infections supposed to have been acquired from a tick were diagnosed with the aid of laboratory findings; one on clinical evidence only.

The sweat bee was alleged to have been responsible for one case that was diagnosed on clinical evidence only. Mr. Allmann of the State Entomologist's office, asserts that the sweat bee leads a solitary existence in tunnels in the soil. It is classified now as Halictidae. It was previously classified under the title Andrenida. There are twenty-five to thirty species belonging to Halictidae. These insects have a sting resembling that of the honeybee. The sting is a modified ovipositor. These insects are said not to lose the sting when they use it. The sweat bee is sometimes confused with a fly belonging to the class Syrphid. However, this fly is not provided with a sting or with a biting mouth part.

5. Williams, Ralph B.: Tularemia, First Case to be reported in Alaska, Public Health Reports, 61: 875-876, June 14, 1946.

Analysis of Cases Acquired From the Rabbit

Table III shows the mode of acquiring infection in the ninety-one laboratory positive cases attributed to the rabbit in Table II. Of the ninety-one cases, fifty-six were males and thirty-five were females. The sex difference is statistically significant.

Nineteen of the fifty-six males acquired the infection while hunting or dressing the carcass of an infected rabbit; twenty-nine while dressing the rabbit and preparing it for cooking; five while hunting, dressing, and cooking rabbits; and three were infected while handling rabbits under other conditions.

Only five of the thirty-five females who acquired tularemia from rabbits were infected while hunting or dressing the carcass, or preparing it for cooking; one while hunting, dressing, and cooking; and two handled the rabbit under other conditions.

Apparently dressing the rabbit and preparing it for cooking were the most frequent methods of acquiring infection. It was the reported method in 61.5 per cent of ninety-one cases of the disease.

Table III

Analysis of 91 Laboratory positive Cases of Tularemia in which the Rabbit was Described as the Source of Infection

Sex	Handled Rabbit While: Hunting and/or Dressing	Dressing and preparing for cooking	Hunting Dressing and Cooking	Handled Rabbit under other Conditions	Total
Male	19	29	5	3	56
Female	5	27	1	2	35
Total	24	56	6	5	91

Table III shows the mode of acquiring infection for the 91 Laboratory positive cases attributed to the rabbit in Table II. The sex difference is significant.

Precautions Against Infection

Table IV lists the precautionary methods employed by eighty-six persons who acquired tularemia while dressing and preparing rabbits for cooking. Seventy-four (86 per cent) used no precautions. A need for education on this hazard is indicated.

Table IV

Precautionary Means Used in 86 Laboratory Positive Cases of Tularemia Reported Acquired while Dressing and Preparing Rabbits for Cooking

	Number
Rubber Gloves	3
Alcohol Wash	5
Soap and Water	3
Soda and Water	1
None	74
Total	86

In Table IV are shown the precautionary methods employed in 86 cases acquired while dressing and preparing rabbits for cooking. A need for education on this hazard is indicated.

Reported Industrial Outbreak

In March 1946 two Greensburg physicians reported data that appeared to indicate a small industrial outbreak of tularemia. One long established industry located near Greensburg is the Standard Fertilizer Company. This firm makes fertilizer and extracts fats from the carcasses of animals.

In March 1946 Dr. J. Morrison reported three cases of tularemia and Dr. Robert Acker reported one case. Each of the patients was an employee of the Standard Fertilizer Company. All of the patients complained of muscular weakness, joint pains, a "run down" feeling, malaise, pain in the muscles, chills and fever. One had enlarged, painful, suppurating axillary glands. None could remember an initial infection. The patient with the enlarged, painful axillary gland gave a history of previous infection that progressed to suppuration. Biopsy done at that time revealed a pathology suggesting tuberculosis. All of the patients had positive serology. The reactions occurred in dilutions of 1:40, 1:160, 1:320 and 1:1280, respectively.

Further study revealed that each of these men had hunted intensively in the past and each still enjoyed this sport. The date of infection could not be determined in three of the cases. The date of onset of symptoms was also very vague and indefinite. In only one instance was the date of onset definitely stated, February 1, 1946.

Although the study of these cases did not appear to support the original hypothesis, that rendering plants might be an industrial hazard for tularemia, data from this one small plant were considered inadequate and further study was planned. A questionnaire was developed. The co-operation of the management of the plants, of local physicians, and of health officers was sought.

The results of the study are summarized in Charts V, VI, and VII.

Chart V

In Chart V the data collected from the Wachtel Company of Indianapolis are tabulated. Column I classifies the various jobs in the plant; cooking room, meat cutter, trucker, laborer, maintenance, truck mechanic, fireman, superintendent, foreman, and general. Columns 2 to 9, inclusive, list the negative reactions in the various jobs by years of employment. In columns 11 and 12 the positive reactions are tabulated, the titer in column 11, the years of employment in column 12. The two reactions occurring in significant titer were obtained from serum submitted by maintenance workers employed at the plant for four years. These results do not suggest that infection with tularemia is related to activities in the plant. A comparison of the activities of the two maintenance workers, inside and outside of the plant, might alter the conclusion.

TULAREMIA IN AN INDIANA RENDERING PLANT
BY OCCUPATION AND LENGTH OF SERVICE

Wachtel Company

Kind of Work	Negative Reaction: Period of Employment — Under 1	1-2	2-3	3-4	4-5	5-9	10-14	15-19	20-over	Total	Positive Reaction: Titer	Positive Reaction: Period of Employment (yrs.)
Cooking Room		1				1				2		
Meat Cutter	1									1		
Trucker	4	2	2		1	4	2	1		16	1/20	1/2
Laborer	1		5	3	3	1		1	1	13	1/40	1/3
Maintenance	1				1					2	1/80	4
"											1/40	4
Truck Mechanic	1									1		
Fireman	1						1			2		
Superintendent								1		1		
Foreman	1									1		
General									1	1		
Total	10	3	5	3	5	5	3	3	2	40	4	

Chart VI

Data collected from seven rendering plants is tabulated in Chart VI. Seventy-seven of the eighty-eight employees are included in this summary. Data is classified by type of reaction and by duration of employment. The first section of Table VI tabulates the length of exposure under the title "Negative Reactions." From left to right the length of exposure is designated as under 1 year, 1-4 years, 5-9 years, 10-14 years, 15-19 years, and 20 years or over. The total man years of exposure were respectively 11, 79½, 82½, 100, 70, and 168.

INDIANA STATE BOARD OF HEALTH
Division of Public Health Statistics

VI

REACTION BY YEARS OF SERVICE IN SEVEN INDIANA RENDERING PLANTS

TULAREMIA

	NEGATIVE: Under 11	1-4	5-9	10-14	15-19	20 over	Total	POSITIVE 1/80 and over: Under 1	1-4	5-9	10-14	15-19	20 over	Total
TOTAL EMPLOYEES	22	25	11	8	4	7	77	0	3	0	1	0	2	6
TOTAL MAN YEARS EXPOSURE	11	79½	82½	100	70	168	—	0	12½	0	12½	0	404	—

Data collected from other plants is shown in Table VI, classified by reaction and duration of employment. No significant reactions occurred among employees in four of the seven plants. These included 33 of the 88 employees of the seven plants.

In the second section of the table data relative to employees having significant positive serology, that is, in dilution of 1:80 or more, is listed. Of these, four had been employed for a total of twenty-five man years and two for a total of forty man years. No significant reactions occurred among employees of four of the seven plants.

Table VII

Table VII summarizes the data of Table VI according to employment of less than or more than five years duration. The differences between the percentages shown in the final column of this table, 5.7, as compared with 11.4, are not statistically significant. The preceding column, showing man years exposure per positive reaction, 38.2, as compared with 125.1, might indicate a relationship between this occupation and infection with tularemia if immunity to subsequent infection was acquired. Since repeated infection has been known to occur, this relationship should probably not be considered significant on the basis of this small number of cases.

Since this data was recorded four more plants with seventy-seven employees were studied. All of these employees had negative reactions for tularemia. However, one gave a history of clinical tularemia several years ago.

INDIANA STATE BOARD OF HEALTH
Division of Public Health Statistics

VII

RELATIONSHIPS OF PERCENTAGE OF RENDERING PLANT WORKERS SHOWING POSITIVE REACTION TO YEARS OF EXPOSURE

TULAREMIA

Period of Employment	Total Exposure Man-Years	No. of Individuals Tested				Reactions 1/20—1/1280	
		Negative	Positive 1/20, 1/40	Positive 1/80—1/1280		Man-Years Exposure per Positive Reaction	% of Employees Positive
Less than 5 years	111.5	47	3	3		38.2	5.7
More than 5 years	500.5	30	1	4		125.1	11.4

Table VII summarizes the data of Table VI according to employment of less than or more than 5 years duration. The difference between the percentages shown in the final column of this table is not statistically significant. The preceding column showing Man-Years Exposure per positive reaction might indicate a relationship between this occupation and infection with tularemia if immunity to subsequent infection was acquired. Since repeated infection has been known to occur, this relationship should not be considered significant on the basis of this small number of cases.

Conclusion

Tularemia has been present in Indiana from time immemorial. It has been a recognized menace since 1914. The data presented herewith is in accord with the conclusion that little can be done to eradicate the animal reservoir. More should be done to disseminate information relative to prophylaxis. Tularemia is a hazard to any one who handles wild rabbits and may also be transmitted from many other small, wild animals. Tularemia is apparently not an occupational hazard in rendering plants.

PROGRESSIVE DAMAGE TO BLOOD VESSELS CAUSED BY DIABETES

Present day treatment of diabetes holds no hope for averting progressive damage to the blood vessels, according to Henry Dolger, M. D., of New York.

Writing in the August 16 issue of *The Journal of the American Medical Association*, Dr. Dolger, who is from the Metabolism Service of Mount Sinai Hospital, presents a review of 200 diabetic patients, not one of whom escaped retinal hemorrhage, regardless of age of onset, severity of diabetes or type of treatment used. The retinal hemorrhages produced partial or total blindness in 27 patients, states the author. The onset of the disease occurred before the age of 50 in the 200 patients who were selected from the metabolism clinic of Mount Sinai Hospital and private practice on the basis of detailed medical records dating from the onset of diabetes, with emphasis on regular examination of the eyes, determinations of blood pressure and complete urinalyses, according to the physician.

There were 55 juvenile patients in this group, including 19 whose diabetes began before they were 10. A breakdown by method of treatment indicates that 20 patients were under excellent diabetic control, that is they adhered to a moderate carbohydrate, low fat diet and exhibited little or no sugar in the urine. Within a range of six to 22 years' duration, retinal hemorrhages were noted in all, with an average duration of diabetes of 13 years when the earliest lesions were observed. By the time that disease of the retina had developed 50 per cent of the patients had high blood pressure and 30 per cent had albumin in the urine.

Another group of 18 young patients, in whom only a fair degree of diabetic control could be obtained, presented retinal hemorrhages within five to 20 years after onset, the average duration of diabetes for the group being 10.4 years. At this time one third of the 18 patients had high blood pressure and albumin in the urine.

A third group of 17 young patients resisted control of their diet; therefore they were allowed to eat as they pleased. The incidence of retinal hemorrhage was noted between five to 19 years after the onset of diabetes, an average group span of 12.4 years. High blood pressure was present in 40 per cent of these patients and albumin in the urine in 64 per cent.

In a group of young adults aged 20 to 29 the appearance of retinal hemorrhage was noted between four to 22 years after the onset of diabetes, with the average duration for the group of 13.3 years. In the group aged 30 to 39 retinal hemorrhages appeared between three to 24 years after onset, the average duration of diabetes being 13 years for the group. In the oldest group, 40 to 49 years of age at time of onset, there was evidence of accelerated degeneration of the blood vessels with the earlier appearance of all the abnormal findings with even greater frequency. The retinal lesions were noted between zero to 20 years after onset of the disease, the average duration being 10 years.

Dr. Dolger believes that the most significant deduction to be drawn from this study is that the duration of diabetes rather than the method of treatment is the most important factor in the development of degenerative changes.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

GENERAL PRACTICE

THIS, the General Practice number of THE JOURNAL, is dedicated to that great host of practitioners who labor in this field of healing. Their heritage is a rich and fruitful one and is evident in the major role they have portrayed throughout the centuries, from the blind, groping eras of ritualistic practices, down through the ages to the present day employment of scientific measures and methods in the care of the sick. They have been, and are, a major element in the lives and health of all peoples; and their contributions to, and participation in, the progress of medicine have elevated them to the highest estate in the sphere of medical care.

The accomplishments of the past and the performances of today, however, are not sufficient supports to maintain their position in the ever-challenging, forward movement of medical practice in the future. Even now we witness the attempts to decry the worth and to limit the activities of the general practitioner. In these pages will be found the answers to the varied and often belittling charges that have been brought against him. Here you will find a statement of his obligations; a portrayal of his function as related to the specialist; a picture of what he is attempting to do in the further elevation of his own standards of practice; a definition of his role in the protection of his calling; an account of his position as a citizen and community leader; suggestions on the matter of his histories and records; a representation of his needs in relationship to the modern hospital, and, for good measure, a number of scientific articles witnessing his knowledge and ability in his chosen profession.

Such an exposition should bring a measure of comfort and pardonable pride to the man who has lately felt himself standing on the doorstep of medicine, hat in hand, while his more aggressive brethren slam the door in his face. There is encouragement, too, in the fact that a different attitude on the part of the hospitals is becoming evident in making room for the general practitioner. The House of Delegates of the American Medical Association and its Council on Medical Education and Hospitals, the Advisory Board of Medical Specialties, the American Board of Surgery and

several other specialty Boards and Societies, and numerous state medical associations and county affiliates have endorsed the feeling that certification in a specialty should not be a requirement for staff appointment in a hospital. The widespread organization of sections on general practice in the American Medical Association and many state and county societies has bolstered the position of the man in general work. The formation of a national organization, with state and county affiliates, and devoted to the welfare of the general practitioner, has been inaugurated recently. The interest being encouraged in the furtherance of postgraduate education and the ultimate certification of the general man have strengthened his importance. The indications that special courses in general practice will be developed for the undergraduate will enhance the appeal of this type of practice. More rigid requirements for specialization, including a preliminary period in general practice, are being voiced and will do much to break the trend toward over-specialization.

The increasing attitude of respect for the general man, on the part of the specialist, and his acceptance as a working colleague, rather than an incompetent competitor, is helping to quiet the hostility that has been threatening to disrupt the ranks of the profession.

These, and many more, are demonstrations of the fact that the problems of the general practitioner are receiving recognition and that his place in medical practice, professionally and economically, must receive the appreciation it merits.

Applicable to the role of the general practitioner are the words of a very wise and experienced Indiana man of medicine. He wrote: "This rejuvenation must begin in groups such as this, in the little county medical society. Its members must realize that there is an acute need for rejuvenation, that every eligible man in the county must enlist in the cause, and that before enlisting he must be 'born again.' Yes, he's got to 'get religion,' and that religion must be of the old camp-meeting, fire-eating kind. We must return to the days when a doctor was a doctor, and when a member of the medical profession was the most respected man in the community. When that is done, and not until that is done, will medicine as a profession be restored to its former place of honor, and not until then will we be free from the attacks of those who would control and destroy us."

Yes, there *are* brighter days ahead for the general practitioner.

PHYSICIAN TRUSTEES OF INDIANA UNIVERSITY

IT WILL come as a surprise to nearly everyone to learn that Dillon Geiger, M.D., who recently was elected by the State Board of Education to serve as a trustee of Indiana University, is the eighteenth physician to receive this honor.

Following is the list of these eighteen doctors of medicine, arranged in the order of their election, with period of service.

David H. Maxwell_____1820-1837, 1839-1852
John W. Jenkins_____1820-?
William B. Laughlin____1832-1836
William C. Foster_____1834-1838
Chester G. Ballard_____1836-1839
David G. Mitchell_____1838-1841
William T. S. Cornett____1841-1852
John W. Davis_____1846-1848
Joseph G. McPheeters___1852-1855
Joel B. McFarland_____1855-1857
James D. Maxwell_____1861-1892
Louis Humphreys _____1861
Daniel Dayton _____1861-1866
John S. Irwin_____1870-1875
Alfred Patton _____1875-1879
Erastus W. Ellis_____1875-1876
Samuel E. Smith_____1916-1925
Dillon Geiger _____1947-

The dates of appointment reveal the remarkable fact that 16 of these 18 physicians were elected during the first 55 years of the history of Indiana University, 1820 to 1875, and that during the last 72 years (1875 to 1947) only two physicians, Doctors Smith and Geiger, have been elected to this office.

The explanation of this marked contrariety is found in the fact that in those early years, 1820 to 1875, the physician was recognized as a man of exceptional learning. It was a period when the percentage of illiteracy was high. In the latter part of that period academies and seminaries were dying out and high schools were being organized, but the number was small and enrollments were low. In 1873 there were 78 high schools in Indiana, with an enrollment of 5,000.

Today, although the formal education of the physician is far better than that of the physician of 1820 to 1875,* he shares the distinction of education with hundreds of thousands of other well educated persons, many of whom have been zealous in civic service, to whom the physician, too often, has yielded the field. This has been unfortunate, for in the long run both the community and the physician profit by participation of the physician in civic affairs in addition to public health.

The physicians of those early years served at great personal sacrifice. Travel was slow and difficult. A letter written in 1853 by William Daily, President of Indiana University, to Michael Malott

* Dr. Cornett, for example, who did premedical and medical work at Transylvania University, was an exceptionally well-trained physician for his day, yet he began the practice of medicine at 19 years of age.

of Bedford urged him to come up to a meeting of the Board of Trustees, of which he was a member. The president wrote: "I would suggest to you to come this (Sunday) evening as far as Colonel McCrea's, then take an early start on Monday morning and you can be here by the time the Board meets." The minutes of the Board of Trustees show a board member occasionally a day late at a meeting, because of high water.

In spite of all difficulties and hardships, however, these physicians gave faithful service. From 1820 to 1892, with the exception of a brief interval, 1857 to 1861, there was always one, often two, sometimes three, and for a short period four physicians on the Board of Trustees of Indiana University, and that at a time when the Univeristy had no School of Medicine.

Some of these physician trustees were very interesting and important persons. We present thumbnail sketches of a few.

David H. Maxwell was a Kentucky man by birth and received his education at Danville, Kentucky, where, later, he studied medicine with the noted Dr. Ephraim McDowell. In 1810 he came to Indiana and began practice at Madison and Hanover. In 1816 he was a member of the Constitutional Convention. In 1819 he moved to Bloomington and in January, 1820, was named a member of the first Board of Trustees, in the legislative act establishing Indiana Seminary. He had a great zeal for education and served for 30 years as a trustee, much of the time as President of the Board. He also served repeatedly as a member of the General Assembly.

William B. Laughlin was born in Pennsylvania. After serving an apprenticeship to a hatter, he went to Philadelphia where he spent six years in the study of surveying, law, and medicine. His study of medicine was under the direction of the famous Dr. Benjamin Rush, one of the signers of the Declaration of Independence. In 1812, with his wife and children he came west to Kentucky. Just before Indiana was admitted as a state (1816) Dr. Laughlin came over into Indiana and located at Brookville where he practiced medicine and taught school. He had three pupils who became Governors of Indiana, James Brown Ray, 1825-1831; Noah Noble, 1831-1837; and David Wallace, 1837-1840. He served in the State Legislature, was assigned to survey Rush County, where he bought 320 acres of land for $400, where Rushville is now located and where he made his home. There is a tablet on the Court House grounds of Rushville, erected by the citizens of Rush County, "To the honor of the man who may be called the first and most prominent citizen of Rushville, Dr. William Laughlin."

Dr. William T. S. Cornett was a Kentucky boy, orphaned at an early age. He completed his general education in Transylvania University. He studied medicine under a preceptor and spent one year in Transylvania University School of Medicine. His funds exhausted, he came to Indiana when 19 years of age to begin the practice of medicine. After a year in Dearborn County he located permanently in Ripley County at Versailles. He served for six years in the Indiana Senate, and for eleven years as a Trustee of Indiana University. He established horticulture and floriculture in Ripley County. He was the first President of the Indiana State Medical Association, and a contributor to many medical journals. For forty years he was one of the most influential men in Ripley County.

Dr. John W. Davis of Sullivan County was born in Pennsylvania. He got his training in medicine in the Baltimore Medical College. In 1823 he came to Indiana and located at Carlisle. He served in the Indiana Legislature, where he was Speaker of the House. He was a Congressman, 1843-1847, and Speaker of the House in the 29th Congress. He was United States Commissioner to China, 1848-1851, and was appointed by President Pierce, Governor of Oregon Territory.

Dr. Joel McFarland was a prominent, much-loved physician of Lafayette, active in fraternal orders.

Dr. James Maxwell, son of Dr. David H. Maxwell, father of Dr. Allison Maxwell, served for 31 years as a trustee of Indiana University.

Dr. Louis Humphreys of South Bend was commissioned Lieutenant Colonel by President Lincoln, and served with distinction in the Army of the Potomac. In 1861 he was elected a trustee of Indiana University, and was seated and attended a few meetings of the Board. He resigned to assume his military duties and was succeeded by his colleague of South Bend, Dr. Daniel Dayton. In 1878 he was elected President of the Indiana State Medical Association, but his strenuous army life had drawn so heavily on his vitality he could not serve, so the state secretary carried on.

Dr. Alfred Patton had an interesting career. He was born in Hardin County, Tennessee. During the Mexican War, 1846, he served in the First Mississippi Rifles (Jefferson Davis' Regiment). He studied medicine and in the Civil War he was Surgeon in General Maxey's Brigade. He resigned because of ill health and in 1863 came north and located at Vincennes.* He was thrown into jail because of seditious utterances, but was soon released. In December, 1863, he took part in organization of the Knox County Medical Society. In 1875 he helped organize the Tri-State Medical Society and was elected its Secretary.

These physician trustees were all busy men, who traveled over poor roads, yet they found time for civic service.

With a minimum of three years of premedical collegiate work, four years in the medical course, and two to four years of postgraduate work, the physician today receives the most extensive and specialized training of any of the professions. The

* The location of Dr. Patton in Vincennes is suggestive of widespread sympathy with the southern cause found in Southern Indiana in the early days of the Civil War.

Governor and the State Board of Education are to be congratulated on drafting a representative of this group (Dr. Dillon Geiger) to serve with other well-trained and devoted trustees of Indiana University, who have been doing such creditable service in the development of all departments of Indiana University.

THE NURSING PROBLEM

EVERYONE concerned with medical care is aware of the prevalent apprehension regarding the nursing shortage. The existing limitation in the number of hospital beds has been further increased by the fact that numerous hospitals have been compelled to close whole floors and sections because of inadequate nursing personnel. Many training schools throughout the country have found themselves in the desperate position of having as few as four or five applicants for admission to their courses. The situation has become so critical that the Advertising Council, Inc., of New York, has initiated a program of nurse recruitment as a public service project. Widespread radio appeals, display advertisements, and copy for local and national presentations have been supplied. The facilities of the American Medical Association, the American Hospital Association, the American Nurses Association, the National League of Nursing Education, the National Organization for Public Health Nurses, the National Nursing Council (representing fourteen professional organizations), and, of course, many state and county medical and nursing associations have all been employed in the effort to bring forth the solution of the problem and to stimulate the interest of young girls in entering the profession of nursing.

Indiana medicine has long been aware of the problem and, through a special Committee on Shortage of Nurses, under the chairmanship of Dr. C. J. Clark, has been endeavoring to effect an understanding with the Indiana State Nurses Association and the Indiana State Hospital Association, to the end that an agreement may be reached on principles, practices, and policies that will facilitate an increase in the number of nurses in training and also provide shorter courses for practical nurses and nurses' aids.

A joint committee of the nurses and hospital associations has now reached agreement on basic matters of controversy and has presented a report and recommendations to be used by the two associations in seeking common objectives relating to hospital service. These are primarily directed toward the relationship of the hospital with the graduate nurse. They recognize the urgent need of improvement in personnel practices by hospital administrators; job analysis and clarification of duties; a firm basis of salary levels with increases on merit; and an appreciation by the nurses of the necessity for twenty-four hour nursing service three hundred sixty-five days per year as a patient obligation.

Summarized, the recommendations include:

Eight hours per day, forty-four hours per week, exclusive of meals.
Elimination of broken hours, so far as possible.
Meal periods of not less than thirty minutes.
Compensation for holiday duty, by additional pay or equal off-duty time.
Elimination of overtime, so far as possible.
Brief rest periods.
Adjustments regarding sick leave.
Minimum vacation of twelve days with pay, after six months service, within employment year, and with consideration for others.
Six legal holidays.
Salary rates on a state and not a community level.
Recommendations to apply to graduate, registered nurses.
Definition of duties of Graduate Staff Nurse.
Definition of Assistant Head Nurse.
Definition of Head Nurse.
Definition of Supervisor.
Minimum salary for graduate nurse $180 per month, all cash, with increases as merited.
Minimum salary for Assistant Head Nurse, $190 per month, all cash, with increases as merited.
Minimum salary for Head Nurse, $200 per month, all cash, with increases as merited.
An appreciation of the twenty-four hour clause by the nurses.
Written notice of all policies, rules and regulations, review of same and changes as indicated.
Advisory committee on personnel policies in the hospital, composed of representative employees.
Continuation of the Joint Committee; a consultant to carry out its purposes; publication of the studies and recommendations for use of the members, the cost to be paid jointly.

Each association has accepted this joint committee report and recommendations as a working agreement. While it does not have the force of a signed contract and its acceptance is on a voluntary basis, the Committee on Shortage of Nurses believes "that every hospital in every county of the state should abide by the terms of this agreement if twenty-four hour hospital nursing service is to be available."

Directing their efforts chiefly toward increasing the recruitment of nurses and nursing personnel the Committee on Shortage of Nurses of our state association has presented recommendations to the Council which have been unanimously approved.

They comprise:

1. Each county medical society should form an advisory committee to girls who wish to enter nurses' training.
2. A pamphlet is to be printed, containing all the facts these girls should know about a nursing career, and to be distributed to all

high schools, libraries, ministers, and all civic groups comprising a point of contact for dissemination of information.

3. The provision of six scholarships of $200 per year each in order to defray a good portion of the cost of tuition, uniforms, and other items.
4. Co-operation of the entire membership of the state association in the enrollment drive.
5. Co-operation and help of the physicians in the drive of the Junior Chamber of Commerce to secure candidates for nurses' training.
6. Support of the Joint Committee of Hospital and Nurses Association recommendations, and a continuous effort to see that hospitals conform.

It was further suggested that perhaps some compensation to the nurse in training, after the first year, might be effected through legislative action, and state subsidy of nursing schools provided, such as is done with Normal Schools.

The problem of securing practical nursing personnel through shorter periods of training may find solution in the licensing, by the Board of Examination and Registration of Nurses, of such hospitals as do not have a training school for graduate nurses, but are sufficiently equipped and staffed to render practical training. The mechanism for such training has been set up and funds may be available through a tie-in with vocational training. The difference lies in the fact that while practical, "on the job" training can be provided in hospitals having nurses' training schools, such trainees will not be accredited, while if such practical training is provided in a hospital licensed for this purpose only the trainee can become an accredited practical nurse.

It is gratifying, therefore, to see that Indiana is emerging from the confusion which has surrounded the whole problem of nursing shortage, and that on the basis of agreements and recommendations a definite start can be made in stimulating interest in a nursing career and assisting in the recruitment drive. The interest and help of the medical profession is urgently needed.

CONVENTION RESERVATIONS

If you are unable to get a reservation, in the hotel of your choice, we will try to assist in finding other accommodations. Just write

**Clarence E. Boyd, M.D., Chairman,
Convention Housing Committee,
French Lick Springs, Indiana.**

Editorial Notes

THE JOURNAL is indebted to Dr. Eugene F. Boggs, of Indianapolis, secretary of the Section on General Practice, for his assistance in planning the material in this special General Practice of Medicine issue. Doctor Boggs selected the scientific papers to be used, and requested various members of the Indiana Board of General Practice of Medicine to write the special articles appearing in this issue.

Dr. John D. Van Nuys recently has been named by the Board of Trustees of Indiana University as Dean of the University medical school. This appointment seems to meet with general approval of Indiana members of the profession. Dr. Van Nuys is one of our younger men, graduating from the University Medical School some eleven years ago. Practically all his professional career has been spent in the medical school and as a result he has first-hand knowledge of the many problems confronting that institution. THE JOURNAL wishes him every success in his new undertaking.

Our Council recently passed a resolution offering to the three "high men" in each graduating class at the University Medical School a "key." This we believe to be a signal honor, one that will be much appreciated by future recipients.

The Council also has approved the suggestion of Dr. Thurman B. Rice that a "Bureau of Information" be established at the University Medical School. This plan was suggested by Dr. Rice some time ago and now that it has been endorsed by the Council a definite working plan soon will be set up, full details of which will be published at a later date.

The shortage in nursing, the subject of an editorial in this issue of THE JOURNAL, seems to be pretty well discussed in many sections of the state. Up at Kendallville there appears to be no little alarm about the situation, a local paper reporting that in addition to the closing of an entire floor in a neighboring city hospital, the local hospital is very short of nursing help. We trust that all physicians will heed the appeal of our state association committee, headed by Dr. Cy Clark, Indianapolis, and make a personal effort to enlist young women from their home communities in nurses' training. Practically every nurses' training school in Indiana has openings for a number of enlistments and any eligible young woman who is thinking of taking up this profession should have our entire support.

It will be interesting to note the reports on some of the newer drugs used in the treatment of one of our annual scourges, "Hay Fever." Now that the season is well upon us it is likely that every suggested new treatment will receive a thorough tryout. In this connection we get a bit of a "kick" out of the annual "weed cutting" program carried out in many communities. Even though every pollen-producing weed in a single city might be cut, long before the pollenization period that city will have its hay fever, just the same, since pollen is known to travel long distances.

Medical officers in our armed forces continue to show a real shortage in numbers, and a real program of more and more enlistments is again in order. We were somewhat surprised to learn that so many medical officers had decided to return to civilian practice; during the war we had heard many of them expressing themselves as being favorable to a military career.

Another "squabble" in one of our down-state hospitals seems to be coming to an end. Not so long ago we had a similar "program" in another county hospital down in that neighborhood, but the local physicians took prompt, though rather drastic action, and in no time the matter was settled. It is unfortunate that so many of those in "authority" in our county hospitals are not versed in hospital matters nor do they show any desire to learn from the local medical men just what is best in hospital affairs.

An Evansville physician advises that if one has not yet seen a "flying saucer," there is something wrong with him. He declares that one who "sees" these things is but observing opacities in his own vitreous. All of which means that at one time or another most adults note "objects floating in front of their eyes." Personally, we have noted these phenomena on many occasions and have long since come to disregard them. It seems that about every blue moon there arises such tales and some enterprising reporter proceeds to make a series of stories about them. "Flying saucers" just do not exist, reports to the contrary notwithstanding.

The death rate from typhoid fever, at one time a matter of the greatest interest to physicians in general and to health officers in particular, has shown a steady decline in our larger centers of population since 1942. A report in the July 26 *J.A.M.A.* states this decline has dropped from 78 deaths in 1943 to 54 in 1946. However, this low rate still is too high; there is little reason for any deaths from this disease which at one time was a scourge in the country. Well do we recall when "autumnal fever" was expected to appear in most any section of our country. Today a single case brings about a scurrying of our health department, seeking the source of that particular case.

Figures just released by the United States Census Bureau indicate that as of July, 1946, the population of the United States and possessions had reached the total of 141,228,693, a gain of almost ten millions since 1940. A breakdown of these figures shows some interesting things, principally of interest to all Hoosiers that Indiana gained a total of 339,517 citizens—pretty good, that, for one of our smaller states. As was to be expected certain of our "vacation-land" states showed a marked increase in population, notably California, which stepped up about two and one-half millions. Michigan, Washington, Oregon, each came in for quite some increase. We read all about it in several papers, none of which indicated the slightest interest in Wild Cat, our native address, down in Carroll County, but we dare say that thriving community did her bit in bringing about an increase in Indiana's population figures.

The Indianapolis Times recently carried a rather extensive story about two of Indiana's most lovable characters, Newton Booth Tarkington and Dr. Carleton B. McCulloch. Dr. McCulloch was of the "old type" of family physician and while he had a little spare time for one of his hobbies, that of politics, his chief interests were those of his patients. He knew "Tark" as few other Hoosiers knew him and has a copy of about everything the famous author has written. There was an interchange of correspondence between these old friends and neighbors over a long period of years, many excerpts from these letters appearing in *The Times* story. We trust that Dr. McCulloch will, in time, write a book of reminiscences, drawing largely from the Tarkington correspondence, as well as from other experiences. Few men know "Hoosier Life" as does Dr. McCulloch.

A recent event in hospital circles, up in Lake County, seems well worth the recording—referring to the action of two of the hospitals in that county "letting down the bars" and admitting qualified Negro physicians to practice therein. For some time past St. Margaret's, at Hammond, and St. Catherine's, at East Chicago, have admitted colored physicians, while Mercy and Methodist, at Gary, have refused such privileges to this group. Now the regulations have been altered and qualified colored practitioners are admitted to the four major hospitals—to treat colored patients, of course. Now colored folk get sick as well as others and most of them prefer to have medical attention from members of their own race. In Lake County we have a rather large group of colored physicians who are eminently qualified, both in medicine and surgery, and it seems only fair that these men have the right to the best in hospital service. Just what adjustments will have to be made remains to be seen, but it is our prediction that the outcome will be satisfactory to all concerned.

President's Page

ON TO FRENCH LICK

General Practitioners

EVERYBODY has had their 7th-inning stretch. You are at bat. Waving the willow, step right up to the plate and take a good healthy cut at the ball. Stand tall, look tall, hit tall! Breathe every confidence! Keep your eye on the ball as it comes down the alley. Pass up the bad ones. Swing on the good. Play hard! Play fair! Don't get caught off-base! Score, *score, SCORE!* Your fans are cheering you on. They know that you savvy the game—better and better and still better medical care for all the people.

All Members I.S.M.A.

Within the next sixty days we will meet at nationally famous French Lick. Never before has your great Indiana State Medical Association possessed its present strength, this by every yardstick, numerical membership, soundness of finances, organized verility, influence with allied bodies at the state level and in nationally esteemed recognition. For this, credit is due to all, collectively; because your committees have been pursuing their activities with unusual vigor.

As never before, you owe it to yourself to be at French Lick in October. As never before, more superb accommodations are awaiting. As never before, better instruction courses and better scientific presentations are offered. As never before, will there be more recreation, more fun, more lively entertainment. And, too, our own Dr. R. L. Sensenich, the new president-elect of the A.M.A., will address us. Need more be said?

Delegates

You represent your county societies. Be faithful to their trust in you. The responsibility for conducting the affairs of your great association rests primarily on your shoulders; because, in truly democratic fashion, the House of Delegates is the policy-forming, legislative, and business body of your great association. Without your individual presence and your active participation therein, the very best efforts of your great association easily might prove futile and sterile, and its surging tide of strength dishonorably could ebb into namby-pamby, pretty-voiced impotence.

Be there! Sign your attendance slip. See to it that the wants and wishes of your county society are placed in due form before the House for consideration and solution in the truly democratic process of free men, free physicians.

Councilors

Your comprehensive knowledge of the condition of the profession and of the organized county societies in your individual and respective districts is of inestimable value in the manifold transactions undertaken by the House of Delegates. Your broader contacts and wider experiences are needed in the full and wise consideration of organizational activities at the state level. Your duties are important. Give your best.

Ex-presidents

As past-presidents and former leaders of your great association, you have a background of rich experience in affairs of state. In recognition of all this, the founding fathers of our State Association Constitution have given you lifetime, permanent seats and voices in the House of Delegates. Most definitely you still occupy an honored place, both in our hearts and in our midst. Your well-rounded experience, your maturity of judgment, your ripened wisdom, all thus acquired over the many and now mellow years, all are needed. We welcome you. Lend us a helping hand.

Sincerely,

Floyd L. Romberger

THE GENERAL PRACTITIONER, THE FAMILY DOCTOR—HIS ROLE AND OBLIGATIONS IN MEDICAL PRACTICE

Claude S. Black, M.D.*

WARREN

THE FAMILY DOCTOR is the alpha and omega of the medical profession. He is the one who ushers us into the world and is with us at our departure. He is the doctor who must have a wide knowledge of diseases as a whole, for he acts as a clearinghouse for his patients and sends them, when necessary, to the specialist for expert diagnosis and treatment. When the general public realizes this, instead of seeking its own expert advice, the better it will be, for the family doctor will always send his patients where he would refer his very own.

The family doctor must have a keen insight into human nature, because his duties are varied. Not only does he treat disease, but he makes such intimate contact with the family that he becomes the family adviser. He is also a great civic leader, if he has "sold" himself to the community, and this must be done if he succeeds to any great degree.

* President, Section on General Practice, Indiana State Medical Association, 1947.

After many years of experience in general practice as a "Country Doctor," I have made a few observations which I am going to pass on to you. Above all, you must have tact and tolerance, along with keen observation, for in this field where the laboratory, the x-ray, and the technician are not always readily available, you must depend chiefly upon yourself to diagnose and determine treatment. And, if in doubt, do something palliative, for God is good—nineteen out of twenty will get well anyway.

But for the patient who needs a specialist's care, the family doctor will quickly call upon the best he knows, the one who has had a few years of general practice and who, through this experience, has indexed his mind with the association of symptoms and diseases. Having such a background, this specialist is better able to differentiate, to find connecting links in disease, to render expert service.

A NEW APPROACH TO AN OLD PROBLEM

J. T. Oliphant, M.D.

Farmersburg

AS far back as there is any history of medical practice it has been a business carried on very close to the people and has been a free enterprise. A doctor located wherever he wished to live and applied himself to the service of those who chose to call upon him. Whether he remained in obscurity or gained fame and reputation depended largely on his own capabilities. The people judged his ability and by their favor he prospered.

Practically all doctors began as general practitioners and as their knowledge and skill increased many of them branched out into surgery and other specialties, but always they were "neighborhood doctors," and remained within easy reach and call of their patients. In later years, as hospital facilities grew, many doctors chose a specialty while still in school and prepared themselves for it by postgraduate training before entering practice. This placed specialists a step further away from the people, but near enough that they must depend upon their personal reputations for the business they obtained. The general practice remained and the patients consulted their family doctors about the choice of a specialist, thus keeping the whole medical service as near to the householder as his telephone, and upon an entirely personal basis.

Since the beginning of the war the general pattern of medical practice has been undergoing an accelerated process of evolution which is taking the personal element completely out of it. This process may destroy the general practice of medicine, and may rob the entire profession of its freedom, leaving doctors employed on a salary basis, subject to the wage and hour laws governing other professional workers.

Governmental agencies employing doctors, the Army, Navy, Public Health Department, Veterans Administration, Childrens Bureau, et cetera, have placed much stress upon specialization, so that specialists, themselves, and perhaps a majority of medical teachers have come to believe that the best possible care for sick people is to place them all in the hospital where they can be observed and treated only by specialists. It is pointed out that by this method the diagnosis is more quickly made and the proper treatment is sooner applied.

Such a theory of medical treatment was largely academic until a remarkable economic change took

place in the lives of the American people, a change marked by the universal desire of sick people to be hospitalized. Twenty-seven million people are now enrolled in the Blue Cross Hospital plan, and other millions carry insurance policies that give them free hospitalization. To these may be added the millions of people able and willing to pay their own bills, and the millions of improvident ones who must be hospitalized at public expense. The sum mounts up to a staggering hospital load. It projects a hospital building program that will make beds available for all of the citizens of the United States.

The ultimate effect of centralizing all patients in hospitals is still a matter for speculation. If the belief that all patients can be treated best if only specialists treat them is accepted, it is evident at once that the general practice of medicine is in grave jeopardy. The general practitioner will be limited to minor illnesses, to office treatment of ambulatory cases, and to funneling the more seriously ailing people into the hospital, or into the hands of a proper specialist. This is not a large field, nor one likely to attract talented young men. With the decline of general practice the personal element in medical practice will be completely lost. The family doctor may be replaced by outpatient clinics, staffed by interns and public health nurses. Welfare workers may be trained as visitors to make house calls and determine whether a patient should be hospitalized.

Another phase of this speculation involves the doctors who will staff the hospitals. A proper board of certification will fix the standards of the various specialties and will grant diplomas to such men as are qualified to serve on a staff or to treat people in the hospital. Presumably all diplomates will have ample ability and will have certificates attesting this fact, and the patients will have no reason to exercise any choice of physicians. Logically one physician will be as satisfactory as another. The doctors could, in fact, work in shifts of eight hours or less without detriment to the patient's care. Politics could enter into such a scheme readily enough; influence and pressure might help or hinder a doctor in obtaining a staff position, or in retaining it when once procured. He would have no public to acclaim his ability and he would have no patient who would desire his services above another's. He would have only a certificate attesting his skill, and his training.

Government money, that is, taxpayers' money, must be used for building and equipping so many hospitals. Taxpayers and tax-conscious public servants are going to be interested in the cost of hospitals and hospital care. With the personality of doctors so far removed from the individual interest of the patient it is reasonable to believe that civilian hospitals will be placed in the same category as Veterans Hospitals, Indian Hospitals, and other government facilities, and that all personnel in civilian hospitals will be placed on a salary basis. Thus, by a purely scientific and somewhat exalted approach to the question of the best possible medical care, the doctors may arrive at precisely the same place toward which Wagner, Murray and Dingell have been trying to drive them.

THE GENERAL PRACTITIONER—A DEFINITION OF HIS ROLE IN MEDICAL PRACTICE

N. K. Forster, M.D.

HAMMOND

At a time when solidarity of opinion and unanimity of action are so essential in the determination of the future of medical practice, we find the ranks of the profession troubled with dissension, crimination, and recrimination concerning the alleged activities of specialty board diplomates, special societies, and hospital staff reorganizations and appointments. It is time, perhaps, to pause and evaluate the role of the general practitioner in the "changing order" of medical practice.

It is no longer a source of satisfaction to speak of the general practitioner in glowing terms and with flattering praise; such phrases as "the bulwark of medical practice," "the backbone of the profession," and kindred expressions have a brassy note of hypocrisy about them. With the present tendency to decry his accomplishments and limit his activities these become no more than a sop to bolster his morale while more and more restrictions are placed upon his industry and further obstacles are thrown in his economic pathway.

There are many who do not pull their punches. By them he is described as a relic of the horse-and-buggy days. He becomes an excellent topic for sentimental journalistic reflection. He is a classic example of the man who knows less and less about more and more. He has failed to keep abreast of the times. He is floundering in the mass of advancing knowledge and he will not admit his limitations. He fails to distinguish between the trivial and the serious. He cannot subscribe to unity of thought and purpose and he is overwhelmed by an abject sense of inferiority. All of this is his own fault, and if he had taken measures to correct these conditions he would not now find himself in this unhappy position.

Well, "let's take a look at the record." There are, admittedly, men in the field of general practice who must plead guilty to this indictment, just

as there are many men in specialized fields who lack practical experience and whose only claim to specialized knowledge is a preparatory residency and a certification to the fact that an examination has been passed in a special field. The only defense of the former must be that they have been so occupied in caring for their patients that they have had neither the time nor the opportunity to devote themselves to long periods of training nor, in many instances, to frequent refresher courses. There is no defense for the latter in assuming a superiority of ability or masterful knowledge of a field, the first requirement or which should be a thorough background of experience in general practice.

It has been pointed out by many that from 80 to 90 per cent of illnesses can be completely cared for by the well-trained general practitioner. If this is true, and a glance at the health of the nation at large would indicate that it is, then one can hardly assume that the accusations directed toward the general practitioner are either logical or fair.

There are, approximately, 180,000 physicians in this country, of whom about 160,000 may be said to be in active practice. Of these, about 132,000 are members of the American Medical Association, and of these, approximately 26,000 are certified as specialists and a further indefinite number are practicing as specialists without certification. Recent surveys indicate that only about 10 per cent of graduates of medical schools intend to enter general practice. Thus we see, in little more than a decade, a very rapid increase in the number of specialists and a corresponding decrease of those in general practice. Attention has been directed to the estimate that there is necessity for only 18 per cent of specialists to care adequately for the needs of the public. The number is now estimated at 25 per cent and is steadily expanding. The general man finds himself in an increasingly precarious position. This is evident when consideration is given to the higher fees charged by specialists, the greater prestige accorded them, the influence of specialty teachers in medical centers with the indoctrination of undergraduates in the advantages of specialization, the attitude adopted by many hospitals and medical schools in limiting appointments to specialty board diplomates, the recognition accorded by governmental agencies in rank, prestige, and pay, the prospects for the establishment of large area diagnostic and treatment centers, and the influence of easy money in demanding specialized care.

These factors, and others, have resulted in the vaunted claim that only the specialist is capable of treating diseased conditions, and a growing tendency on the part of the public generally to seek out their own specialist. They are, moreover, setting the stage for regimented medicine, for obviously it becomes a much simpler matter for government to assume control over a group of professional men who have already regimented themselves through rules, regulations, and discrimination. The plight of the general practitioner, under government control, is not apt to be a satisfactory or happy one. If such situations are to persist then the only outlook for the general practitioner is in the role of messenger boy, "feeder," and general slavey for the specialist.

It cannot be said that the difficulties of modern medical practice are essentially greater than those of a decade ago. General medicine, surgical, obstetrical, gynecological, pediatric, and psychosomatic problems are the same. Only the degree of training has changed and the requirements have become more exacting. What formerly may have been a good working knowledge of most departments of medicine is no longer considered adequate. Medicine is being fragmented into specialties, subspecialties, and even single disease specialties, and the tendency to by-pass the general practitioner is becoming more prevalent. This, in turn, means a considerable increase in the cost of medical care and, because of it, inadequate medical care.

Recognition has been given to the dangers of overspecialization. As it looks from here prompt action is required if an adequate balance is to be struck, the health and welfare of the public protected, and the disintegration of medical practice prevented. A voluntary curb placed upon specialization through efforts directed toward augmenting the desirability of a general practice career should be promulgated by the specialty groups themselves, if only as a measure of self-protection, as well as by those in general practice. This may well take the form of adequate recognition by the governmental groups, the hospitals, medical centers, and the public in general. Discrimination in the matter of appointments should, and probably will, be abolished. The prestige of the general man should be enhanced through some form of certification to the fact that he is effectually trained and competent in his profession and that he is abreast of the times. It has been argued that certification in general practice, on a national basis, is not the answer because the state boards of licensure and the national board examinations already indicate that a man who passes them is qualified to enter general practice; that such a step would hinder, and perhaps eliminate, many general men now practicing, and that the position he acquires in his own community is sufficient evidence of his ability. Well, as a matter of fundamental principle, this can be said also of the specialist. Before the advent of the boards men specialized through their own initiative in seeking training and experience under established men or in training centers, and the basis for their recognition, in a limited field, was the position they eventually acquired in the community in which they practiced. It is doubtful that even now such a factor will be influenced, in public regard, by the possession of a certificate. But the fact remains that such a method, instituted in the interests of the elevation of standards of

specialty practice, has resulted in an inequality of position for the general man that has no place in our medical family. If it is necessary to elevate standards in special fields it is equally important to elevate standards in the *whole* field of medicine, and the general practitioner should not be left on the doorstep of medical practice, as a foundling, an unwanted and discarded member of an honorable profession.

In this day and age the majority of men in active general practice are graduates of Class A medical schools and most of them have served a required internship. A large percentage of them regularly attend medical meetings, a great many of them take refresher courses or additional postgraduate work. While a number may not read their medical journals from cover to cover, the majority manage to keep up on current topics of interest through staff conferences, where available, and through contact with their colleagues. In addition, the larger proportion have had from ten to twenty years of experience, and it might be pointed out here that it has been said that no man, specialist or otherwise, is a good doctor until he has had at least ten years of experience. They are not the relics of the horse-and-buggy days that some would believe, the implication of which is that they are "has-beens." Neither are they the abject creatures of pity or inferiority that has been indicated. Most of them are hard-working men of character, with a definite knowledge of medical science and the ability to apply that knowledge in the recognition and treatment of disease.

If it can be said of the general man that he "fails to distinguish between the trivial and the serious," it is also applicable to the specialist, in that, too often, he fails to distinguish between the serious and the trivial. The obvious is too frequently overlooked in the quest for the unusual and, too many times, to the economic embarrassment of the patient. If it can be charged that the general man fails to recognize his limitations, willfully or unwillfully, then the specialist stands equally convicted. It is not uncommon to find the ophthalomologist treating syphilis; the ear, nose, and throat man diagnosing and treating allergic conditions; the pediatrician involved in various surgical procedures; the obstetrician doing pediatrics; the dermatologist engaged in various phases of general medicine; the general surgeon continuing to practice urological, neurological, and chest surgery; the proctologist a general surgeon, before he can qualify as a specialist; and so on through the whole field of medicine. Perhaps the only unadulterated specialists are the men who make the rules, but here, too, there is considerable room for doubt. In spite of the question of recognizing his limitations it must be obvious that the general man is doing a pretty good job in holding up his end in protecting the health of the public. Greater preparation in education, experience, and higher standards of character are necessary to fit a medical man for general practice. The specialist would do well to make a working partner of this man rather than to attempt to restrict his activities.

All such controversial questions, directed at the role of the general practitioner, have no place in the practice of medicine. They create a disharmonious and discordant atmosphere in a field of endeavor that should never be disrupted, and constitute a definite deterrent to the progress and accomplishments of the art and science of medicine.

In view of the present tendency to specialize it seems doubtful, however, that any voluntary curb will suffice to halt the growing trend in this direction. The specialty boards may, if they choose, effectively halt this development of overspecialization by adopting a regulation that requires an initial period of three to five years in general practice before an individual can become eligible to prepare for a specialty certification. The possibilities of such a rule are evident and the assumption that many would not desert general practice after such a period of experience is logical.

Finally, while no one cares to anticipate the effects of a general economic depression, it has occurred before and probably will again. Such a situation has the result of proving a great leveler. It is quite likely that under such circumstances many specialists may find it necessary to return to general practice. The economic phases involved in practice and the high cost of specialization may be adequate factors in adjusting the trend toward overspecialization, and it is not presumptious to indicate that the specialist might do well to anticipate a cordial welcome from his colleague, the general practitioner, by adopting a more co-operative and helpful attitude at the present time.

What then is to be the definition of the role of the general practitioner in medical practice?

With a preponderance of numbers, now estimated at almost seven to one, the answer becomes apparent. New sections on general practice have been created in the American Medical Association organization and in many state and some county associations. A national organization, with component state and county affiliates, devoted to the problems and welfare of the general practice of medicine, the American Academy of General Practice, was formally organized at Atlantic City on June 10, 1947, and through it a great force created for the improvement and standardization of training in general practice and the protection of the interests and privileges of the general practitioner.

The delay of organized medicine in interesting itself in the problems of general practice and the unfair tactics instituted by some specialty diplomates and certain localities and institutions must find adjustment through the organized efforts of representative general practitioners. The aims

and purposes of this new organization are commendable and its progress and accomplishments will be watched with interest. Its success requires the active co-operation of every man in general practice who is concerned about his economic welfare and the elevation of the standards of practice of his calling.

The role of the general practitioner in medical practice today thus becomes one of an interested organizer, a participant in the elevation of the standards of proficiency, and a willing worker in the preservation of the field of general practice in its contacts with hospitals and all other phases of medical work. This will entail the proper recognition by the regulated governmental services; adequate participation on hospital and teaching staffs as an integral unit; attractive standardization and improvement in the training for general practice; the correction of defects and sources of criticism in the ranks of general practitioners; equitable representation in the offices and the deliberations of organized medicine as a whole; special internships and residencies for those who would enter general practice; frequent and accessible postgraduate courses for the general practitioner; the development of preceptor training in general practice through association with recognized men of ability. These and many more are problems with which the man in general practice must concern himself if he does not wish to become enveloped in a cloud of oblivion. The law of supply and demand; the attitude of most of the public in preferring their own family doctor; the danger of encroachment of cult practice; and the fact that of necessity there must always be a need for the general man are all influential factors given to explain why the general practitioner "just won't die out." However, he can be so subjected by rules and regulations of dominant bodies that his identity can be lost if he does not take the necessary steps to preserve it; and if he should ultimately lose it there is little likelihood that the system of free medical enterprise will survive.

Little has been said here about the role of the general practitioner in his relations with the public, nor is there necessity to enlarge upon it. His wealth and variety of human contacts; his innumerable accomplishments in preventive medicine; his alleviation of human suffering; his long hours of service and sacrifice; his aptitude in solving so many of the problems in human emotions; his intimate knowledge of human relations and frailties; and the application of sound medical skill in the recognition and treatment of disease are all accepted and unchanging. It only remains for him to insist that such a valuable and essential background is not eliminated through forgetfulness and neglect. His is an *important* job.

THE MODERN HOSPITAL—ITS ADEQUATE RECOGNITION OF THE NEEDS OF THE GENERAL PRACTICE OF MEDICINE

Harry Pandolfo, M.D.

INDIANAPOLIS

THE modern hospital, regardless of its size or location, has assumed a place of major importance in the daily life of all physicians, be they general practitioners or highly trained specialists. The hospital provides a common meeting ground and workshop for all, and it is only natural that during the present crusade to improve the status of the general practitioner that many of the suggested changes or reforms are centered in these institutions. In the present-day hospital, with a long list of prospective patients and a staff headed by widely known specialists, the general practitioner is likely to be relegated to a position of minor importance on the hospital staff. He eventually finds himself engulfed in a sea of specialists, residents, meetings, sectional meetings, rules, restrictions, and many other obstacles too numerous to mention.

An attempt will be made in this discussion to summarize briefly the many ways in which hospitals may serve the general practitioner better and, in so doing, aid him in giving his patients better care. This must of necessity deal with problems in general, because every hospital and staff are different and the policies must vary, depending upon the local situation. In spite of this, many things can be done in both large and small hospitals to place the man doing general practice in a position where he can feel more secure and have a voice in formulating hospital policies. The following are suggested as means by which hospitals in general may better serve the general practice of medicine.

1. Establish a general practice section, as recommended in a resolution passed by the House of Delegates of the American Medical Association in December of 1946. Such a section would give the general practitioner an opportunity to present and discuss cases of interest to this group. It would also provide a meeting ground where problems could be discussed and, by concerted effort, any existing faults might be more easily corrected.

2. The hospital staff must formulate definite policies regarding just what a general practitioner can or cannot do. This refers certainly to surgery, obstetrics, orthopedics, and many other special

branches of medicine. It is not wise to be too liberal in this policy because much harm could result, but some degree of freedom should be allowed the general practitioner in the matter of doing minor surgery, tonsillectomies, minor fractures, complicated obstetrics, and other minor procedures which he is qualified to perform. This policy regarding what a physician can or cannot do must be definitely stated and very rigidly adhered to. No favoritism should be shown, and no misunderstandings can result if this policy is strictly maintained.

3. The medical governing boards of hospitals should include members of the general practice group in numbers sufficiently large to prevent any injustices to the practitioner in the matter of securing staff appointments and in limiting his activities too greatly. Adequate representation is essential, especially in the larger hospitals, where the general practice group is more likely to be overlooked.

4. In staff sections representing specialties in which much of the work is done by general practitioners it would be well to include among the officers of such sections qualified members of the general practice group. Thus the policies and rules governing practice in these sections will more likely meet the approval of the physicians doing much of the work in these sections.

5. Medical programs presented by the various specialty sections should be provided at regular intervals, directed at broadening the knowledge of the general practitioner and keeping him informed of the progress being made in the various specialties. This would certainly benefit all concerned: patients, general practitioners, and specialists in the various fields.

6. Teaching appointments, when available, should not be limited to men practicing the various special branches of medicine. Many well qualified general practitioners could be given such appointments and do their job well.

7. A final suggestion has to deal with hospital employees in general. Nurses, student nurses, civilian personnel, interns, and other hospital employees who come in contact with patients, should realize the fact that the great majority of hospital patients are in the hospital through the efforts of the family doctor, and because he is the family doctor he is vitally interested in the progress of the patient, even though he has called upon physicians practicing in specialized fields of medicine to aid him in the care of the patient. In many instances the family doctor is in a position to know what is best for his patient, and for this reason it is well that he be kept informed, as far as possible, regarding his patients' progress.

In conclusion, it is sincerely hoped that the suggestions here presented may be studied and accepted in general by many of our hospitals. I am sure that such acceptance would improve the status of the family doctor, he would gain greater respect from his patients and associates, and be able to serve all in a better way.

THE PRINCIPAL AIMS AND PURPOSES OF THE INDIANA BOARD OF GENERAL PRACTICE OF MEDICINE

Harry E. Klepinger, M.D.

LAFAYETTE

THE INDIANA Board of General Practice of Medicine was organized primarily to "encourage the study, improve the practice, elevate the standards, and advance the cause of the general practice of medicine." To accomplish this task it was imperative to institute some type of practical postgraduate education which would be available to all general practitioners.

A family physician rarely has at his disposal a period of uninterrupted time which he may devote to study, to the reading of medical journals, or to otherwise keeping up with the more recent advances of medical science. Nor is he able to leave his practice three or four days every few months to attend "refreshers" in medicine or listen to lectures on recent research. By means of questionnaires it has been ascertained that the most desirable time for postgraduate study and instruction is Wednesday afternoon, once or twice each month, July and August excepted.

Many physicians report a lack of understanding on the part of some teachers regarding the limitations of their postgraduate students. The majority of those attending have been out of school many years and find it far more difficult to comprehend and retain material presented by lecture than they did when they were medical students. This complaint seems to point to a definite need for such supportive devices as printed outlines, lantern slides, and concrete presentation of actual cases. This board will continue to study this phase of the problem and assist in improving the methods of presenting postgraduate courses.

A properly conducted hospital staff meeting can be of great value to the general practitioner from the standpoint of postgraduate training. This is especially true when the educational department of the hospital assumes the responsibility of training a resident in general practice. Unfortunately, many physicians, located in small communities, do

not have the privilege of being affiliated with a live hospital staff. Their alternative is to attend the meetings sponsored by the Indiana Board of General Practice of Medicine at the Medical Center in Indianapolis.

Our board pledges itself to employ every possible method for stimulating continued postgraduate education, which is the surest means of elevating the quality of general medical care and improving public health. The certificate showing proficiency is of secondary importance, although we do believe that the physician who takes an active part in the discussion of medical problems and prepares for an examination derives greater benefit for himself and his community than does the doctor who merely attends the course.

AMERICAN ACADEMY OF GENERAL PRACTICE

LESTER D. BIBLER, M.D.

INDIANAPOLIS

THE American Academy of General Practice was founded at Atlantic City, June 10, 1947. The first meeting was held at the Claridge Hotel, where two hundred nineteen doctors were present to form this association. The actual organization was the result of a feeling among general practitioners all over the country that there should be a concrete body, similar to that of other specialty groups and this is believed to be the answer. Every Doctor of Medicine in good standing has an opportunity to join the Founders Organization, and every General Practitioner in the United States, who can meet the qualifications, is invited to join this national group.

The objects and purposes of this organization follow:

1. To promote and maintain high standards of the General Practice of Medicine and Surgery;
2. To encourage and assist in providing postgraduate study for General Practitioners in Medicine and Surgery, and to encourage and assist practicing physicians and surgeons to participate in such training;
3. To encourage and assist young men and women to prepare, qualify, and establish themselves in general practice;
4. To protect the right of the General Practitioner to engage in medical and surgical procedures for which he is qualified by training and experience;
5. To advance medical science and private and public health.

To be eligible for general membership the applicant must be a physician engaged in general practice. He must be of high moral and professional character. He must have graduated from a medical school approved by the American Medical Association. He must be duly licensed in the state in which he practices, and must be a member of the local medical association of the area in which he practices. He must have had at least one year of rotating internship at an acceptable hospital, or the equivalent in postgraduate training. He must have been engaged in the general practice of medicine for at least five years immediately preceding the date of his application for membership. He must have shown interest in continuing his medical advancement by engaging in some postgraduate educational activities during said five-year period. Under unusual circumstances exception to the foregoing rules can be made by the unanimous vote of the membership committee. A general practitioner is defined as one who does not limit himself to one field of medicine.

Any general membership shall terminate at the end of three years, and to be eligible for re-election to general membership a general member must have maintained his high moral and professional character, and must have spent a minimum of one month during his three-year period in postgraduate training of a nature acceptable to the membership committee. All applications for membership shall be in writing on a form of application prescribed by the Board of Directors. Election or re-election to a general membership shall be by a five-sevenths vote of the membership committee. Any physician failing of election to general membership shall not again be proposed or be eligible for general membership for a period of one year thereafter.

All persons fulfilling the foregoing requirements for membership and registering at the first annual meeting, and those applying for membership within a period of ninety days after the adoption of the by-laws shall be original members of the American Academy of General Practice.

Persons of distinction who are members of the medical profession may be elected by the Congress of Delegates or the Board of Directors to honorary membership in the Association without formal nomination or certification.

All General Practitioners of the Indiana State Medical Association are invited and urged to join and to co-operate with this organization. State organizations are being activated throughout the United States, and to date there has been an unusual amount of enthusiasm and interest shown. There will be a meeting for the organization of the Indiana Section of the American Academy of General Practice, Wednesday, October 29, 1947, at the Indiana State Medical Association meeting in French Lick. Drs. Harry E. Klepinger, of Lafayette, or Lester D. Bibler, of Indianapolis, may be contacted for further information.

THE GENERAL PRACTITIONER—HIS ROLE AS A CITIZEN AND A COMMUNITY LEADER

Robert W. Gehres, M.D.

SHELBYVILLE

TWO WEEKS AGO, during a locker room discussion, a local business man propounded the following: "What has happened to the present-day doctor? I can remember when the local doctors were men of real influence in civic and political matters." The discussion carried on for some little time from this point, and I listened closely. My conclusion is that this business man is largely correct, slightly in error.

During the past ten years in our community the doctors have not been active in the Chamber of Commerce; the doctors do not run or are they elected to county or municipal office; the doctors do not individually, or in a professional group, sponsor or promote moves for civic betterment along general lines or in the matter of general community health.

This inactivity is not the result of the lack of objectives. In our local municipality we still cherish hundreds of the old-fashioned and modern, "new deal" outhouses, with the usual, unpleasant odors and the usual menace of summer fly scourges. We also have dozens of family wells used by their owners or tenants with no real effort to outlaw them or campaign against their use, despite the fact that we have had an excellent municipal water supply available at very reasonable cost for decades.

In our town we have an antiquated, inefficient street cleaning system. We are still contemptuously watching decrepit, ancient pensioners stir the gutter filth about with hand brooms, two to four times a month. We have no modern sweepers or street flushing equipment.

We have only recently passed a restaurant inspection ordinance, and it is not yet in force. As an aside, we are a community of about 12,000, and to date there is not a single, modern, mechanical dishwasher in use in either of our public eating houses.

In our community we have an 1890 model sanitary and storm sewer system. We are dreaming of a new "modern disposal plant." In the meantime, the public, including we doctors, continues to do nothing very aggressively about it, and allows our own fecal material and industrial filth to be dumped into a very beautiful, polluted, fishless, little river, to be mixed with the stinking, fluid mess from upstream communities.

Our town also sports an excellent 1915 model street lighting installation that fits into our 1947 conception of a municipal setup rather awkwardly.

This community maintains a system of narrow gravel streets. These streets have been covered and recovered with sand and oil on so many occasions that it is difficult to drive a car on the side of the crown in dry weather. During the winter months these high crowns, covered with ice, are responsible for dozens of crumpled fenders, cutaneous and bony injuries. Still we travel along, year after year, talk aoout and cuss the streets, but do nothing in the matter of planning or correction.

I hardly believe it necessary to add to the above listing in order to make my point. The term "our town" may be applied with equal truthfulness to every county seat, town, village, or city I have observed during the past ten years, and I have observed several hundred of them.

Author John Gunther was only partially correct when he called Indianapolis the dirtiest city in the United States—he should have included all of our cities and towns. They are dirty in more ways than a lay writer would probably be aware of.

We, as citizens, are paying more in taxes right now than at any time during the lifetime of any of us, and we are getting less for our tax dollar.

This situation, we all agree, is the result of the "apathy of the citizens," and of these I know none more apathetic than the doctors.

Without any intention of presenting myself as a crusader or a leader of lost causes, I believe that I can state that many of these rotten conditions can be corrected by proper leadership and I believe the local medical group should be in there among those leaders, especially in the matter of health and safety. There is no group in any city or town better acquainted with health and safety requirements than the doctors and, even in 1947, there is no group more universally respected for its integrity and broad knowledge.

Now, as to what the doctors can do and have done, I would like to cite a few accomplishments of our local medical group over the year 1946 and the first half of the present year. In January of last year a member of our medical society, who had been away in service several years, was named head of the local board of health. This board inherited several "headaches" in the matter of community health and hospital operation, since this particular city has for many years owned and operated a municipal hospital.

The worst "headache" in community health was the enforcement of the "Grade A" milk ordinance, passed during the war years and bearing a February 1946 enforcement date. On this date, due to actual material shortages, a year's "grace pe-

riod" was allowed the processors. As the 1947 enforcement date approached the health board heard the same, whining excuses or witnessed complete disinterest. An appeal to the local newspapers, the local medical society, and a definite promise of enforcement from the mayor made short work of this attitude. The ordinance went into effect on the date designated. Now we have "Grade A" milk and the apathetic citizens seem proud of it.

In the matter of hospital operation the new board took over a run-down, crowded, dirty, poorly-equipped, and understaffed institution, of which the majority of "apathetic citizens" were surprisingly ashamed. Personnel was shifted to an eight-hour day, salaries were raised to be in line with or ahead of comparable institutions. New equipment and replacements were located and installed. The building was renovated, beds rearranged, and new and better personnel was obtained. Room rents were doubled. The institution is now clean, orderly, and almost efficient in operation.

In addition, the city now has definite plans for structural enlargement. A new law was enacted by the 1947 legislature providing for the spreading of the financial responsibility of the institution, making it now county-wide, and also providing for county representation in a new, distinctly hospital board.

We have our restaurant inspection ordinance, which will soon go into effect.

These recent activities, I feel, are nothing more than a beginning. They are cited merely to illustrate what a county medical society can accomplish in a year and a half in one Indiana county when the members act as a group and can be interested sufficiently to "ditch" occasionally their rather absurd professional superiority and false dignity. We know that we haven't reached any millennium and that our present accomplishments are largely a matter of trying to catch up with neglected, old business. We have learned that when the doctors have intestinal fortitude enough to step up and explain matters to the "apathetic citizens" and City Council, they rather surprisingly fall in line.

I firmly believe that more activity of this variety on the part of the doctors might do much to alter the opinions of the business man mentioned in the opening paragraph of this article and, at the same time, make the doctors' town a healthier, more beautiful, less smelly, and better town for the doctor, his family, and his patients.

MEDICAL RECORDS

Their Importance in the General Practitioner's Office

Mary Keller Ade, M.D.

LAFAYETTE

GOOD medical records are of increasing importance and, while they need not be as complete or elaborate as those of a hospital, those kept in the general practitioner's office should be just as accurate and kept just as faithfully. They should be kept for the sake of accuracy, for permanency, for availability of information and, of course, they should be kept confidentially. No matter what type of system is used the information should be filed in such a way that it is easily and quickly accessible, yet not in plain view of other patients, extra office help, or visitors.

The type of record card or filing system used depends on the individual preference, on the type of practice, the amount of secretarial help, and the amount of filing space in the office. Some physicians use plain typing paper and insert these in Manila folders which are filed alphabetically. This requires large filing drawers. Size 5x8 inch cards seem to be more convenient. These may be obtained in all kinds of special printed forms for various types of cases, e.g., pediatrics, obstetrics, medical, genito-urinary, eye, and E.N.T. While these may have some advantages, we prefer a plain card with only the simplest heading. This includes name, address, age, telephone number and, in the case of children, the parent's name. Additional cards may be stapled together, or if the record becomes too voluminous, or includes laboratory, x-ray, pathological reports, or correspondence, all the data may be inserted into an envelope. We also use these envelopes for a family file where there are several small children.

What is included in the record also varies with circumstances but in general the data mentioned above as a heading is essential. In addition, there should be a brief history, previous treatment or surgery, diagnosis or a tentative diagnosis, and the present course of treatment. Obviously some records will be much more brief than others, and a complete history will be unnecessary. In the case of patients who come in for routine visits, subsequent calls may be abbreviated and may be entered on the card very simply. This is particularly true with prenatal patients, well baby check-ups, immunizations, E.N.T., or diathermy treatments. It also seems highly important to record types of medication given, as no physician's mem-

ory is infallible—unless he uses only a stock set of drugs. Where drugs such as thyroid, digitalis, opiates, or other potent drugs are used it is worth-while to record also the dosage. In the case of immunization, it might be of value to record the name of the company making the drug, also. Drug sensitivities, when known or painfully discovered, should also be recorded on the record, in red pencil or in a conspicuous place. This is particularly true for patients allergic to the sulfonamides, penicillin, or foreign protein, such as is found in certain sera. Major or minor surgical procedures should also be recorded, briefly but accurately. This will be of inestimable value to both patient and physician, and certainly in the event of a change of physicians. The patient's memory is not very reliable either as to dates or procedures. Also, some physicians do not tell patients what has been done during surgery. Even when a patient has been told, his description of an operation is usually more naïve than accurate. More complete records may be obtained from the hospital.

Industrial accidents, compensation cases, and insurance examinations need to be recorded very accurately, especially as to right and left, which digits, degree of burn or injuries, length of time of disability, and loss of function. Even "cause of death" should be written on the physician's record in order that all subsequent insurance blanks might be made out the same.

Additional records, such as x-ray reports, laboratory reports, B.M.R. recordings, electrocardiograms, and pathological reports should be kept with the patients' records and should be kept indefinitely, for several reasons. Even though the patient may die, move to another vicinity, or cease coming to a given physician, his record may still be of importance in medicolegal questions, settlement of estates, insurance claims, or in the writing of a scientific paper or the collection of medical data. The careful preservation of case records may also save the patient costly repetition of laboratory and allied tests.

Records should, of course, be filed alphabetically as to last names so they may be quickly available. Files should be kept securely closed or locked. While the office secretary may remove the cards and file them away, we feel it is better for the physician to write up his own cards. There are times when a very brief history perhaps is of virtue and where a patient's confidence is more important than a complete record. A cross index is of value, particularly when the physician is interested in collecting scientific data or writing papers. The use of "A Physician's Log" helps maintain an easily available index in case it is desired to look up data regarding a certain type of patient. Each day, as the patient's name is entered, the type of case may also be recorded briefly in the center line, e.g., Ob., Gyn., E.N.T., G.U., Ped., or Med. Then, when a certain type of case study is needed the patients' cards may easily be withdrawn and necessary data obtained.

The day is gone when the family physician, now known as the general practitioner, relied on his memory as to the diagnosis, treatment, and prognosis of his patients. Whether we like it or not, the physician's office must be maintained with some semblance of a business concern. This applies to medical case records as well as to financial records. While the latter may be more of a "must," due to government reports and tax payments, the former is equally important to the physician who hopes to give his patients the best in scientific care, in accurate treatment, and the maintenance through the years of his medical history. In the end, accurate records in the physician's office mean better medical care to the patient, which is after all the chief duty of the doctor to his patient.

STATEMENT REGARDING HEALTH AND ACCIDENT INSURANCE

Certain accident and health insurance companies have placed advertising in THE JOURNAL and subsequently have stated or intimated in direct mail and personal solicitation of physicians that their plan is approved or endorsed by the association. No such action has been taken by the association as to any company or policy. More information regarding health and accident insurance will be published in an early issue of THE JOURNAL.

ORDER YOUR TICKETS FOR THE 1947 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1947 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick Springs Hotel, French Lick, is now complete. All classes are on Tuesday, October 28, 1947.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now!

INSTRUCTIONAL COURSE SCHEDULE

Hours	*Parlor A Main Floor*	*Parlor B Main Floor*	*Game Room Mezzanine*	*Radio Room Mezzanine*	*North Porch Main Floor*
11:00 A.M.	The Treatment of the Infectious Diseases of Children Course 1	Genito-urinary Problems of the Elderly Course 6	Treatment of Fractures of the Forearm, Wrist, and Hand Course 11	Management of Colitis and Constipation Course 16	Diagnosis and Treatment of Common Skin Diseases Course 21
1:00 P.M.	Limitations in the Effectiveness of Chemotherapy and Antibiotics in Children's Diseases Course 2	New Techniques in Intravenous Feeding and Therapies Course 7	Backache Course 12	Office and Bedside Heart Examination Course 17	Diagnosis and Treatment of Common Gynecological Problems Course 22
2:00 P.M.	Infant Feeding Problems Course 3	Office Laboratory Tests for General Practice Course 8	Diagnosis and Treatment of Common Skin Diseases Course 13	Management of the Elderly Course 18	Management of Diabetes Mellitus Course 23
3:00 P.M.	Recognition, Diagnosis, and Treatment of Toxemias of Pregnancy Course 4	Minor Surgery for General Practice Course 9	Office Treatment of Anorectal Conditions Course 14	Psychological Management of Patients Course 19	Office and Bedside Heart Examination Course 24
4:00 P.M.	The Rh Factor Course 5	X-ray Demonstration of Chest Conditions Course 10	Office Surgery in Ear, Nose, and Throat Course 15	Diagnosis and Treatment of Eye Conditions in General Practice Course 20	Headache Course 25

Cut on dotted line.

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice....	No.:	No.:	No.:	No.:	No.:
Second choice.	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

Your tickets will be waiting for you at the Registration Desk, October 28, 1947.

Signed: M.D.

Address:



FOR FRENCH LICK

Your hosts, the Committee on Convention Arrangements, the Orange County Medical Society, and the Third District Medical Society, announced in the June issue of your JOURNAL that

"A WHALE OF A CONVENTION IS IN THE MAKING,"

and each month thereafter we have been giving you an extensive preview of the plans and the program for the

French Lick Session, October 28, 29, 30, 1947

Proudly, but modestly, we now announce that "the Whale of a Convention is made," and it will be the greatest session in the ninety-eight years' history of the Indiana State Medical Association.

THREE FULL DAYS OF OUTSTANDING SCIENTIFIC MEETINGS, WITH PLEASING INTERLUDES OF EXCEPTIONAL ENTERTAINMENT AND THRILLING SPORTS EVENTS. THE LARGEST TECHNICAL AND SCIENTIFIC EXHIBIT IN THE HISTORY OF OUR FRENCH LICK SESSIONS. A PANORAMA OF WHAT'S NEW IN MEDICINE. MEDICAL LEADERS FROM COAST TO COAST ARE ON THE SCIENTIFIC PROGRAMS OF THE SECTION AND GENERAL MEETINGS, PLUS AN INTENSIVE POST-GRADUATE SEMINAR OF TWENTY-FIVE INSTRUCTIONAL CLASSES ON TIMELY MEDICAL SUBJECTS, TAUGHT BY AUTHORITATIVE INSTRUCTORS.

All this, and more, we promise you under the one big top of America's greatest inland convention and pleasure resort.

Please review the convention pages in your June, July, and August JOURNAL for detailed program and hotel information, and read the Official Program in the October issue; and, as *our last call,*

Your hosts, the grass roots doctors of Orange county and the Third District, cordially invite you to attend the three full days of the greatest convention ever attempted by the Indiana State Medical Association, climaxed by the annual banquet on Thursday night, honoring our own Roscoe L. Sensenich, president-elect of the American Medical Association.

At your service,

The Orange County Medical Society
The Third District Medical Society
The Committee on Convention Arrangements

1947
SPORTS PROGRAM
French Lick Springs Convention

GOLF, TRAP AND SKEET SHOOT, TENNIS, BOWLING, BILLIARDS, BADMINTON, ARCHERY, AND HORSEBACK RIDING ARE ALL ON THE FRENCH LICK SPORTS MENU THIS YEAR.

WRITE YOUR OWN TICKET BELOW

GOLF TOURNAMENT

The famous Donald Ross, French Lick Hill course, reconditioned and in excellent shape, (with a new Club House and a new Half-Way House to comfort and refresh the golfer) will be the site for this year's great post-war ISMA Golf Tournament. It will be an eighteen hole medal play event, with many exceptional prizes for low gross, low net, and blind bogey scores. Starting time, 8 A.M., Tuesday, October 28.

HERBERT P. SLOAN, M.D., CHAIRMAN
MEL SMITH, PRO, STARTER AND HANDICAPPER



TRAP AND SKEET SHOOT

Hunters, Trap and Skeet Shooters, we will be looking for you Tuesday morning, October 28, at 9 o'clock, at the French Lick Springs Gun Club, located on top of the hill on the Dairy Road in back of the hotel. We will have plenty of shells and all equipment and facilities to thrill the Nimrod. Trophies well worth shooting for.

WILLIAM E. SCHOOLFIELD, M.D., CHAIRMAN

BOWLING TOURNAMENT AND BILLIARDS

The spacious Bowling and Billiard Casino located beneath the Main Convention Hall will be the Mecca for convention doctors, their wives, and guests, on Wednesday night, October 29. A bowling tournament on the perfect, four-lane alley, with attractive prizes, is planned, and there are tables available for those who like to chalk a cue.

JOHN K. SPEARS, M.D., CHAIRMAN

ARCHERY, TENNIS, AND BADMINTON

The French Lick Springs Hotel has an excellent battery of tennis and badminton courts, with the famous Har-Tru surface construction, and archery range for those who enjoy the thrill of sending an arrow straight to its mark.

SADDLE HORSES AND BRIDLE PATHS

Spirited three- and five-gaited saddle horses are on call for those who desire an early morning canter or an evening trot over the beautiful wooded bridle paths in the hills of Orange County.

In order that we may plan for you in advance, please check below your sports desires and mail at once to:

CONVENTION ARRANGEMENTS COMMITTEE
212 Elsby Building, New Albany, Indiana

Get me a caddy for the Golf Tournament. ☐

I plan to shoot Tuesday morning. ☐

Give me a horse I can ride. ☐

There are.....members of my family who plan to play:

Tennis: ☐ Badminton: ☐ Billiards: ☐ Archery: ☐

Name..... Address.....

Official List Of Hotel Accommodations, Rates, And Information

1947 Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick

OCTOBER 28, 29, AND 30

FRENCH LICK SPRINGS HOTEL

Convention Headquarters—600 rooms.

Rooms with bath for single occupancy—$13.00 daily.

Double rooms with bath, twin beds, in de luxe section ("A" section)—$12.00 per day, per person, when occupied by two.

Double rooms with bath, twin beds, main section, and all other outside locations, $11.00 per day, per person, when occupied by two.

Double rooms with bath, back of house, facing dining room, kitchen, and roofs, $10.00 per day, per person, when occupied by two.

Rooms with lavatory and toilet only, for single occupancy, $10.00 per day.

Double rooms, lavatory and toilet only, $9.00 per day, per person, when occupied by two.

Rooms with running water only, $8.00 per day, per person, whether occupied by one or two.

Room rates include all meals, including the annual dinner on Thursday night, October 30. The new owners of the hotel have discontinued breaking down the American plan day into quarters as has been the custom for many years, and have substituted the following system of charging for part days:

Breakfast	$1.50
Lunch	$1.50
Dinner	$2.50

For example, after a guest has completed a full American day of occupancy of his room, but remains for an extra meal or two, when he checks out he will pay for only the full day rate plus the charge for the extra meals, at the prices quoted above.

West Baden Springs Hotel, formerly The Homestead, West Baden—92 rooms.

Double rooms with bath—$5.00 double; $3.00 single.

Double rooms with toilet (no bath)—$4.00 double; $2.50 single.

Double rooms with running water (no toilet or bath)—$3.50 double; $2.00 single.

(Food is not included in above prices).

New Harrison Hotel, West Baden—29 rooms.

Rooms without bath—$2.00 per person.

Doyle's Tourist Home, West Baden—14 rooms.

Rooms with bath on halls—$2.50 double; $1.50 single.

Pierce's Tourist Home, West Baden—6 rooms.

Rooms with bath on halls—$2.50 per person.

Claxton House, French Lick—20 rooms.

Rooms with bath on halls—$1.50 to $2.00 per person.

Grand Hotel, French Lick—30 rooms.

Rooms with bath on halls—$2.00 per person.

(Food is not included in any of the above prices).

A list of available rooms in private homes located in the French Lick-West Baden district is being compiled by the Convention Arrangement Committee. Address inquiries to Dr. C. E. Boyd, co-chairman, in care of French Lick Springs Hotel, French Lick, Ind.

Make Reservations Direct with the Hotel of Your Choice.

Medical Panorama by the Associate Editor

WISCONSIN reports that in a survey of 1,049 medical graduates since 1927 16 per cent are now practicing in rural areas. "Of the graduates, 499 are practicing in Wisconsin, 177 of them in communities of less than 10,000 people, and 322 in communities larger than 10,000. Of the latter, 79 are in training or not in practice. The rest of the group are scattered over 42 states and 7 foreign countries."

Another note of interest is "the preceptor plan by which students spend 12 of the 48 weeks of their senior year with general practitioners in Wisconsin." Highly satisfactory in giving the student a feeling of responsibility and active participation, the plan has also proved effective in inducing graduates to remain in rural practice.

———ISAM———

MICHIGAN reviews the activities of the Veterans Administration during 1946. Hospitals increased from 97 to 122. Beds increased from 79,450 to 97,772 (23 per cent). Admissions 458,749, an increase of 61.3 per cent. General medical and surgical cases 83 per cent of the total. Operation of 200 hospitals eventually anticipated.

———ISAM———

CONNECTICUT, acting through its House of Delegates, has passed a resolution dealing with staff membership in hospitals. It is suggested that:

"1. Adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners, as well as specialists, shall have access to, and use of, hospital facilities.

"2. That the criterion of whether a doctor may be a member of a Staff or Head of a Department shall be his actual ability as a doctor, and not dependent on special society or Board membership."

———ISAM———

MINNESOTA records a different concept of the supply of medical service from the old standard of physicians-population ratio, utilized for so long. The director of the A.M.A.'s Bureau of Economic Research, Dr. Frank G. Dickinson, believes that this method "has no economic meaning whatsoever." He has graphically shown "that **trading areas**—not county boundary lines—more properly determine the outline of Medical service areas." Dependent upon attractive shopping centers, transportation, amusements and service facilities, medical service areas are increased or decreased in proportion to the size of these trade areas.

NORTH CAROLINA lists their legislative achievements of the past year: "(1) the adoption by the legislature of the medical care program; (2) the agreement of the nurses to modify, temporarily at least, their demand for an all-nurse board of examiners; (3) the passage of a bill to license practical nurses who have had one year's hospital training; (4) the defeat of 'the perennial osteopath bill'; and (5) the defeat of the naturopath bill."

———ISAM———

NEW YORK comments on a recent survey made by the New York Times of the major countries of the world. An increasing trend toward nationalization is shown. "The prospects for the survival of the competitive free enterprise system outside the Western Hemisphere seems covered with uncertainty in view of the growth of nationalization under various forms of socialism and communism." The influence of this trend in this country is pointed out in past reference to "economic royalists," the "wooing of the labor vote," the "sponsorship of compulsory health insurance," the "N.R.A. and A.A.A.," and the "contempt for constitutionality and precedent." They hope "that our current leadership with the backing of the people will heed Dr. Franklin's admonition, 'You have a republic—if you can keep it.'" A definite role for the physician to exercise his influence in the preservation of our concepts is indicated.

———ISAM———

COLORADO has appointed a Disaster Commission with representation from all parts of the state. A state-wide medical relief group will function in aiding local agencies with personnel and facilities on request. All types of emergency catastrophes will be serviced.

———ISAM———

TEXAS reports on their recent legislative results. Basic Science, the Revised Medical Practice Act Bills, and the Hospital License Bill failed of passage, as did the measures providing for a Cancer Hospital, near Dallas, and a medical branch of the University of Texas, at San Antonio. However, the chiropractic and naturopathic bills also were defeated. The Coroner's Autopsy bill, the Hospital Construction Bill to enable participation in the Hill-Burton Law benefits, and additional Tuberculosis Service were passed.

What's Going On In Indiana by the Executive Secretary

Scholarships for Nurses. The Council of the Indiana State Medical Association, which last January voted to establish six $500 medical school scholarships, took action in July to give scholarships of $200 each to six girls entering nurse's training in any one of the twenty-eight accredited nursing schools of the state. The Council, too, decided to award medals in the name of the association to the three students with the highest grades in each graduating class of the Indiana University School of Medicine. Nobody can impugn the motives of the association, which are crystal clear. The medical school scholarships are to help worthy medical students who need financial aid, and since the recipient must practice in a community in need of a doctor, for a period of five years after his internship, the scholarships will help alleviate the shortage of doctors in rural areas. The nursing school scholarships will enable six girls to become nurses who otherwise might be denied the privilege because of lack of finances. And how we need those nurses! The senior medal awards are to encourage medical students to study more diligently.

——ISMA——

Vanderburgh County Progresses. The Vanderburgh County Medical Society (172 members) has joined the ranks of county medical societies employing full-time executive secretaries, being the third county society in the state to take such action. The other two counties are Marion and Lake. And, like Marion and Lake counties, Vanderburgh's local dues are now $35 a year. The society is helping to finance its expanded program through a contract with township trustees for care of indigent patients. But the arrangement can best be told by Dr. William M. Cockrum, president of the society: "Vanderburgh county physicians, for approximately twenty-seven years, have donated their services to indigent hospitalized cases. They received no fees for surgical or medical care of this group of patients. We ran a survey of the state rather recently and found that Vanderburgh county was one of only three counties in Indiana where such a situation existed. We concluded that it might be wise for us to attempt to rectify this condition. We were aided in our research by the Tax Research Bureau of Evansville. We found that the township trustees were paying about 39 cents out of the tax dollar to hospitals and about 6.5 cents to the doctors for medical care. We further found on a state-wide survey of township payments for individual medical care that the doctors were paid nearly 12 cents out of the tax dollar and the hospitals were paid 20 cents. We concluded that the hospitals in this area were receiving more than their share. We planned then to pass this information around for consideration by the various interested groups. I might say that we were rather warmly received in all instances when we suggested that it was our intent to ask for a direct payment to the medical society for these services, and at the same time provide for a group of interested doctors to study rising hospital costs on these patients and attempt to lower these costs in any manner that we deemed advisable, bearing in mind the interest of the patient and the interest of the taxpayer. We were able to formulate contracts which have been signed by each of the township trustees and have been approved by the State Board of Accounts. We are receiving a total of $765 per month from the township trustees in this county at the present time. This is on a trial basis of one year, during which time we are called upon to show a saving in hospital costs." Arthur P. Tiernan, Indianapolis newspaper and public relations man, has been selected as the executive secretary. He will begin his duties September fifteenth.

——ISMA——

The Hoosier Doctor's Wife. A new publication has appeared in Indiana—*The Hoosier Doctor's Wife*. With financial help from the state association, the Woman's Auxiliary has begun this mimeographed bulletin which will appear every few months. It will keep the doctors' wives informed as to what is going on in auxiliary and medical circles. Eventually it will be printed. The first issue says that the purpose is to "bring our members closer together in a common cause; to increase our membership by encouraging new county auxiliaries and members-at-large in counties where there is no auxiliary; to alert all Indiana physicians' wives that our relations with the public depend on our being well informed and actively interested in health, health education, medical legislation, medical insurance plans, etc. The aims of the medical profession have been and can further be extended by doctors' wives working together in a group." Mrs. A. W. Ratcliffe of Evansville, state auxiliary president, is editing the bulletin. Incidentally, a School of Instruction, broken down into four study groups, has been arranged by the auxiliary during the annual session at French Lick in October. More power to the good women!

——ISMA——

This and That. County medical societies have been asked by the Veterans Committee to submit a list of members who are qualified specialists. The Veterans Administration insists on having this information. . . . The next meeting of the executive committee of the state association will be on September 21. . . . The Indianapolis Medical Society had 875 members August 1, the largest membership in its history.

News Notes

Dr. Maurice A. Turner is now associated wi h Dr. Harvey Stork, of Huntingburg, for the practice of medicine.

Dr. Rollin R. Shannon has opened an office in the Community Hospital, in Williamsport, for the practice of medicine and surgery.

Upon completion of a two year residency in surgery at the St. Louis Jewish Hospital, Dr. Joseph H. Tuchman has returned to Indianapolis where he plans to practice.

Formerly on duty at Randolph Field, Texas, Lieutenant W. L. Kenoyer has been transferred to the 430th AAFBU, ADC, Harrisburg, Pennsylvania.

Drs. Ross E. Griffith and Robert P. Jay of Indianapolis, have moved their office to 401 East Thirty-fourth Street.

Dr. Leroy E. Burney, state health commissioner, was honored recently with election to the vice-presidency of the newly-formed Indiana Public Health Association.

Dr. Pierre DeLawter, formerly of Indianapolis, hopes to begin practicing in the Pasadena, California, area soon. He was discharged on June second after forty-seven months of duty with the Navy. Twenty-six months were spent overseas aboard the *USS Wilson* (DD408).

Robert E. Jewett, M.D., director of the Division of Maternal and Child Health of the Indiana State Board of Health, has been appointed secretary-treasurer of the Association of Maternal and Child Health and Crippled Children Directors by the officers and the council of the association. Dr. Jewett replaces Viktor O. Wilson, M.D., director of Maternal and Child Health and Hospital Services of the Minnesota State Department of Health. The association is a national organization composed of the state and territorial directors of Maternal and Child Health and Crippled Children's Services.

The forty-ninth annual convention of the American Hospital Association will be held September twenty-second through September twenty-fifth, in St. Louis. Two Indiana hospital administrators are on the program: Robert E. Neff, administrator of the Methodist Hospital, in Indianapolis, and Sister Mary Reginald, administrator of Mt. Mercy Hospital and Sanitarium, at Dyer.

Dr. Lester D. Bibler, of Indianapolis, was appointed as one of nine directors of the American Academy of General Practice, which was formulated during the annual session of the American Medical Association recently.

Dr. John DeFries, of Muncie, has opened an office for the practice of medicine in New Paris. Doctor DeFries is a graduate of the Indiana University School of Medicine, and served a fifteen months' residency in pediatrics at the Indianapolis City hospital, following which he practiced in Muncie for two years. He is a veteran of World War II.

Interstate Postgraduate Meetings

The International Assembly of the Interstate Postgraduate Medical Association of North America will be held in the St. Louis Auditorium, in St. Louis, October 14 to 17, 1947. The 1948 Assembly of this Association will be held at the Public Auditorium in Cleveland, the week of November 8, 1948.

Recently discharged from the Navy, Dr. C. F. Deppe, of Franklin, has opened an office for the practice of medicine in Edinburg. Doctor Deppe is a graduate of the Indiana University School of Medicine, and he took postgraduate work at the University of Cincinnati.

Dr. Howard J. Henry has opened an office for the practice of medicine in Knox. A graduate of Indiana University School of Medicine, Doctor Henry spent his internship in Indianapolis City Hospital. He served for three years with the Army, seven months of which were spent in Germany, and was discharged with the rank of captain.

Dr. Thomas C. Haller, of Williamsport, has become associated with Dr. H. C. Wallace, of Crawfordsville, in the practice of surgery there.

A native of New Palestine, Dr. Edgar A. Hawk has opened an office for the practice of medicine in Greenfield. He graduated from the Indiana University School of Medicine in 1942, and served his internship at the Medical Center Hospitals. From July 1943 until June 1946 Doctor Hawk served with the medical department of the United States Navy, and spent more than twenty-four months in the Pacific theater of war. Since his separation from the Navy he has been a resident physician at the Ball Memorial Hospital, in Muncie.

Dr. David Eisenberg, formerly of Chicago, has announced the opening of his office for the general practice of medicine at the Whiting Sanitarium, 90 West Harrison Street, Martinsville.

Announcement has been made by Dr. Basil Dulin of the opening of an office for the general practice of medicine in the Weiler Building, in Portland. Dr. Dulin served for five years in the Army Medical Corps. For three and a half years he was confined to a Japanese prison camp, having been taken a prisoner on Bataan.

Miss Constance E. Andrews, of Franklin, and Dr. John F. Beardsley, of Frankfort, were united in marriage on June twenty-ninth, in the First Presbyterian Church, Franklin. Dr. and Mrs. Beardsley have established residence in Frankfort where Dr. Beardsley has opened an office for the general practice of medicine at 51 South Jackson Street.

Following a four months' residency at the City Hospital in El Paso, Texas, Dr. James Farr has become associated with Dr. Leon Gray in the general practice of medicine. His offices are at 171 East Washington Street, Martinsville.

Dr. Norman E. Forsee, of Jeffersonville, has been appointed health officer for the city of Jeffersonville, to fill the unexpired term of Dr. J. H. Baldwin who retired from active service several months ago.

Dr. Robert L. Gammieri has opened an office for the general practice of medicine at 3326 Clifton Street, Indianapolis.

Dr. Thomas H. Hewlett, who has been associated with Dr. William Garner, 919 East Spring Street, New Albany, has joined the staff of the American Oncologic hospital, Philadelphia cancer control center, for two years of specialized training in cancer work.

In order to accept a position as resident physician at the East Haven State Mental Hospital, in Richmond, Dr. Leslie Laird, of North Webster, has resigned as Kosciusko County coroner.

Dr. Iva M. Miller, formerly a medical missionary for twenty years in China, has established an office at 224 North Meridian Street, Indianapolis.

Dr. L. J. Thill, formerly of Fort Wayne, has opened an office in Ashley, for the general practice of medicine and surgery.

Dr. Richard N. Washburn, of Rensselaer, has closed his office in Rensselaer to become a member of the staff of the Elmhurst Clinic at Elmhurst, Illinois, where he will specialize in internal medicine.

The Eleventh Councilor District Medical Association meeting has been changed from Wabash to Peru. The meeting will be held Wednesday, September 17. The change was made at the request of the Miami County Medical Society, in order to honor Dr. J. E. Yarling, of Peru, who is a charter member of the Eleventh District Medical Association, and who has been in practice for fifty years.

Dr. C. H. Marchant has returned to Bloomington to resume medical practice. Doctor Marchant has been absent for seven years, five of which were spent in military service. Upon being separated from the Army Doctor Marchant first took a year's postgraduate work in ear, nose, and throat at the University of Pennsylvania, and then served an ear, nose, and throat residency at the Episcopal Hospital in Philadelphia.

Dr. William Province, of Franklin, has been awarded the Bronze Star Medal by the United States Army. The citation accompanying the medal reads: ". . . for exceptionally meritorious service in connection with military operations, as Assistant Chief of Medical Section, Second General Hospital, European Theater of Operations, from August 15, 1944 to May 4, 1945. Major Province, because of his thorough professional knowledge, initiative and outstanding devotion to duty, performed his duties in a superior manner. His cheerful and pleasant demeanor was a constant source of inspiration to both his patients and co-workers and contributed materially to the high standards of the Medical Department, reflecting great credit upon himself and the armed forces of the United States."

Dr. Paul D. Williams, of Martinsville, became connected with the Veterans Hospital, Cold Spring Road, Indianapolis, on July 15. He is doing neuropsychiatry. Dr. Williams was medical superintendent of the Richmond State Hospital for three and one-half years.

American Roentgen Ray Society Meeting

The 48th annual meeting of the American Roentgen Ray Society will be held at Haddon Hall, in Atlantic City, September 16 through 19, 1947. Dr. Raymond C. Beeler, of Indianapolis, is president of the society. Speakers on the program include: Dr. Merrill C. Sosman, of Boston; Dr. Ralph S. Bromer, of Philadelphia; Dr. W. Walter Wasson, of Denver; and Dr. U. V. Portmann, of Cleveland. Dr. B. R. Kirklin, of the Mayo Clinic, Rochester, will be in charge of the Instructional Courses each afternoon during the meeting. Dr. R. A. Arens, of Chicago, is in charge of the scientific exhibit.

Radio Program Time Change

A new time of presentation has been announced by the Bureau of Health Education for the AMA-Mutual Broadcasting System weekly radio dramatization, "Stephen Graham, Family Doctor." This program, recently extended to November 17, will now be aired each Sunday afternoon at 3 o'clock, Central Standard Time.

Dr. Norman E. Beckes, who has practiced medicine in Vincennes for more than fifty years, paid a visit to state headquarters recently. He is the father of Dr. Ellsworth W. Beckes, of Vincennes, and a brother of Dr. Lyman M. Beckes, who was practicing in Vincennes at the time of his death in 1907. Doctor "Norman" delivered Red Skelton, comedian, who is a native of the city. The Beckeses are a pioneer family, having lived in Vincennes for ninety-three years.

Dr. Ralph H. Beams, formerly in practice at Fairmount, from 1937 to 1941, is opening an office for the practice of ophthalmology at 517 Wayne Pharmacal Building, in Fort Wayne. Since his discharge from the Army, in July, 1945, he has been resident in ophthalmology at the Indiana University Medical Center. Doctor Beams was assistant chief of the EENT Clinic at the Station Hospital in Camp Polk, Louisiana, during 1941. He went overseas in 1943, and was Batallion Surgeon with the 5th Army. He was discharged with the rank of captain.

The Chicago Ophthalmological Society will give a 40-hour refresher course December 8 to 13, inclusive. The faculty will include members of the Eye Department of the University of Chicago, The University of Illinois, Loyola University, Northwestern University and staff members of all of the principal hospitals of Chicago. Instruction will consist of didactic and practical courses, emphasis being placed on the practical courses given to small groups. Physicians practicing ophthalmology, and eye, ear, nose, and throat are eligible for the course. The fee will be $100.00. For details write to the registrar, Miss Maude Fairbairn, 8 West Oak Street, Chicago.

Colonel Charles L. Maxwell, a graduate of Ohio State University and since 1917 with the Regular U. S. Army Medical Corps, has been appointed medical director of the West-Central branch office of the Indiana State Board of Health in Terre Haute. Colonel Maxwell assumed charge of the Terre Haute office on September 1, after spending several weeks in the State Board of Health central office in Indianapolis acquainting himself with Indiana's public health problems.

Dr. Charles Hupe of Lafayette celebrated his 90th birthday on July 26th. Born and educated in Germany, he received his medical degree there in 1882 and emigrated to America the following year, starting practice in his present location. He has been treasurer of the Tippecanoe County Medical Society for 45 consecutive years. At present he has but one peeve: "When I inherited the treasurer's job, we had only $29 in bank; now we have over $1200 and it would be many times that if we did not have so many spendthrifts in the county society."

AIM Medical & Surgical Film Catalogue

Believing that professional motion picture films can be of great value in bringing to practitioners and to medical students the advances in medical knowledge, the Academy-International of Medicine has compiled a list of the films now available, indexed by topics, and including the source from which they may be obtained by the borrower. As a service to the profession the Academy is offering to mail, upon request, to any members of the Indiana State Medical Association, a complimentary copy of the AIM Medical and Surgical Film Catalogue. Requests should be addressed to: Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

American College of Surgeons Clinical Congress

The thirty-third annual Clinical Congress of the American College of Surgeons, including the twenty-sixth annual Hospital Standardization Conference, will be held at The Waldorf-Astoria, New York, from September 8 to 12. The five-day program features operative and nonoperative clinics in 38 hospitals in New York and Brooklyn, and scientific sessions in general surgery and the surgical specialties, official meetings, hospital conferences, medical motion pictures, and educational and technical exhibits, at the headquarters hotel. Dr. Howard A. Patterson of New York is Chairman of the Committee on Arrangements.

Second Annual Postgraduate Course in Diseases of the Chest

The American College of Chest Physicians is sponsoring a second annual postgraduate course in diseases of the chest, to be held during the week of September 15-20, 1947, at the Municipal Tuberculosis Sanitarium, Chicago. The emphasis in this course will be placed on the newer developments in all aspects of diagnosis and treatment of diseases of the chest. The course will be limited to 30 physicians. Tuition fee is $50.00. Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Dr. Hugh S. Collett, son of Dr. George A. Collett, formerly of Crawfordsville, is now associated with the Caylor-Nickel Clinic of Bluffton, as a resident in Surgery in the Clinic Hospital. Dr. Hugh graduated from Northwestern University Medical School in 1946, and completed his internship in June 1947 at the University of Chicago Clinics.

Dr. H. G. Weiss of Evansville sailed from San Francisco September 5 for Hong Kong, China, where he will begin an inspection tour of hospitals of the Board of International Missions of the Evangelical and Reformed Church. He will complete his visitations in China by December 15 and will fly to Calcutta, India, where he will spend two and a half months inspecting the board's hospitals in India. He expects to arrive home about March 15. Doctor Weiss was invited to make the visits as medical consultant to the hospitals and advisor for the board. He intends to call at hospitals of other church denominations as well as government and university hospitals. Doctor Weiss is a past president of his county and district medical societies.

Instructional Course in Allergy

The American College of Allergists has announced that its annual fall Graduate Instructional Course in Allergy will be given in Cincinnati, Ohio, November 3-8 inclusive, under the auspices of the Medical College of the University of Cincinnati.

The program this year is the best ever offered by the College. Forty-six formal lectures are listed, as well as a special allergy clinic of case presentations. An added feature this year will be three informal discussion groups led by various members of the faculty.

The faculty is composed of more than forty outstanding physicians and scientists from prominent medical centers and colleges in the United States and Canada. The course presents a comprehensive study of the entire field of allergy, covering the fundamentals, special allergies, specific diseases, and all modern methods of treatment. Symposiums on dermatologic and pediatric allergy are also included, as well as a survey of the laboratory approach to the subject, including preparation and standardization of extracts and skin testing.

The course is recommended to all who are especially interested in allergy, and to the general practitioner and specialist who anticipates treating his own allergic patients. It is designed to provide a more comprehensive understanding of the many manifestations of allergy so commonly encountered by the doctor, and to emphasize methods of diagnosis and treatment so that he can offer worthwhile aid to those who come to him for help.

Programs and complete information can be obtained by writing to the College Secretary, Dr. Fred W. Wittich, 423 La Salle Medical Building, Minneapolis, 2, Minnesota.

Lake County Medical Society Host to Indiana Board of General Practice

On September 17, in Gary, the Indiana Board of the General Practice of Medicine will meet with the Lake County Medical Society and the Tenth District Medical Society, in an afternoon and evening meeting, featuring a program on industrial medicine produced by Lake County men, a tour of the world's largest steel mill, and a dinner. Doctors are urged to bring their wives. The ladies will be welcome to tour the mill, and will enjoy the dinner and the dinner program.

Program

1:30 P.M.—Tour of Carnegie Illinois Steel Corporation, as guests of J. C. Donchess, M.D., medical director, and the steel corporation. Ladies welcome.

4:00 P.M.—Scientific meeting, Hotel Gary, Mezzanine floor.

Subject:

Aluminum Therapy in the Treatment of Silicosis—David R. Johns, M.D., East Chicago.

Discussion Leader—S. J. Petronella, M.D., East Chicago.

Fractures—J. C. Donchess, M.D., Gary.

Discussion Leader—A. C. Remich, M.D., Hammond.

Burns—A. V. Cole, M.D., Hammond.

Discussion Leader—E. H. Carleton, M.D., East Chicago.

Evaluation of Disability—E. S. Jones, M.D., Hammond.

Discussion Leader—T. J. Smith, M.D., Whiting.

E. H. Carleton, M.D., medical director of Inland Steel Company, and chairman of the Lake County Medical Society Program Committee, will be in charge of the scientific session.

6:30 P.M.—Dinner, Crystal Ball Room, Hotel Gary.

Speaker—Dr. Julius E. Lips of New York City, formerly with the Department of Anthropology in Cologne.

Subject—*The Role of Medicine in Primitive Society.*

C. M. Jones, M.D., Whiting, Tenth District Director for the Board of General Practitioners, will be chairman of the dinner meeting.

Harry Klepinger, M.D., of Lafayette, president of the Board of the General Practice of Medicine, expresses a desire for all members who possibly can to attend this outstanding meeting and to bring their wives. Any doctor in the state will be welcome, according to David R. Johns, M.D., president of the Lake County Medical Society. Dr. Johns urges, however, that doctors wishing to attend the meeting make reservations by addressing the Lake County Medical Society, 504 Broadway, Gary, stating how many will make the mill tour and how many wish dinners.

INDIANA UNIVERSITY NEWS NOTES

Establishment of a Department of Public Health and a Department of Microbiology to replace the former Department of Bacteriology and Public Health has been announced.

The Department of Public Health is being headed by Dr. Thurman B. Rice, of Indianapolis. Dr. Rice will devote his entire attention to this subject as a part of the medical school's curriculum and to development of a School of Public Health at the university's Medical Center.

The Department of Microbiology is headed by Dr. Randall L. Thompson, formerly on the faculty of the Medical College of Virginia. Dr. Thompson will continue his investigation of the growth requirements of viruses and the chemotherapy of viral diseases. Establishment of an independent Department of Microbiology is in keeping with current trends in medical education, and places the Indiana University Medical School among the few medical teaching centers in the nation to offer this integrated course of study to students.

Indiana University's School of Medicine in September will admit 141 students, its largest class in history.

Dr. C. H. McCaskey, of Indianapolis, chairman of the faculty committee on admissions, in announcing the list of students admitted, said that ninety per cent of the class are veterans, most of whom will take their medical training under the "G.I. Bill." All except six of the 141 students are residents of Indiana.

The list of those admitted is as follows:

James H. Belt, Frederick R. Carpenter, John H. Caughran, Aubrey P. Cullen, Jr., Myron K. Dill, Elmer J. Eisenbarth, Orville E. Fosgate, Donald L. Foxworthy, Warren E. Gammell, William R. Gibson, Morgan E. Greene, Walter L. Hurt, William A. Huston, Richard H. Jowitt, Joseph P. King, Willie T. Leffler, Kiril K. Liaptcheff, John D. MacDougall, Thomas P. Magenis, Torvald O. Mahrling, Richard G. Mehne, Joseph A. Miller, Roscoe E. Miller, Arthur B. Millis, Richard G. Moores, Victor H. Muller, Earl J. O'Brian, Robert N. Pitts, Robert G. Reed, Frederic A. Rice, Jr., James B. Riley, Jeanne Rybolt, Arthur C. Sanders, Robert R. Simpson, and Paul L. Webster, Indianapolis;

Colvin H. Agnew, Philip M. Allen, William E. Brandt, Mary Julia Gottschalk, Margaret Jane Hitzeman, Marguerite Kurth, James R. Mensch, Linus J. Minick, Juan S. Rodriguez, and Robert E. Welty, Fort Wayne; Raymond D. Dwyer, Jr., Peter E. Gutierrez, Takashi I. Inouye, Lorraine Neumann, Lloyd S. Sampson, Andrew Thomson, Jr., and Richard W. Wagner, Gary; Theodore L. Bosonetto, John C. Forsyth and William J. Lewis, Terre Haute; John L. Gediga and Harold F. Goodman, East Chicago; Pat Stalteri and Wayne H. Thompson, South Bend; John B. Anderson, Roscoe A. Lanning and Harry B. Parmenter, Jr., Vincennes; David C. Beck, Maurice J. Carlisle, Drexel K. Drehmel, Michigan City; Paul J. Hettle, Wandel O. Miller and Robert M. Reid, Bloomington; Joan Wilson and Kenneth Wright, Evansville; Betty Hathaway and Alfred E. Hollenberg, North Manchester; Kendall O. Burns and Hugh A. Townsley, Huntington;

James W. Bond, John H. Williams and Duane I. Gillum, Richmond; Herbert C. Ashmore and Philip K. Wiley, Lafayette; Jane Newman and William H. Smith, Muncie; Charles E. Conaway, Kenneth E. Burroughs and Edward M. Wisniewski, Hammond; Herbert C. Kennedy and Thomas A. Weldon, Aurora; Robert D. Boone, and Glenn Owens, Oakland City; Robert Keyes and Dean E. Wildman, Peru; Eddie R. Apple, French Lick; George P. Backer, Ferdinand; Paul H. Bauman, Batesville; Wilbur P. Beeson, Hagerstown; Warren L. Bergwall, Marion; Marvin R. Bernard, Jr., Hobart; Charles E. Black, Lowell; Charles T. Brown, Sullivan; Frederick R. Brown, Poseyville; John T. Burns, Hartford City; Jennie Buyer, Francesville; Don P. Coffin, Crawfordsville; Harry Danielson, Jr., Plymouth; Raymond E. Duncan, Bedford; Kenneth W. Eskew, Boonville; Seymour Fisher, New York, N. Y.; Stephen R. Fromm, Springfield Gardens, N. Y.; Gordon B. Gish, Tipton; Thomas H. Gouchnour, Jacksonville, Fla.; Mrs. Irene Greenhut, Union Mills; Dallas C. Hail, Tell City; Charles E. Hendrix, Petersburg; Philip G. Hershberger, Miami; Thomas Jean, Orleans; James G. Kidd, Jr., Roann; Paul E. Kindy, Middlebury; Charles W. Landis, Logansport; Earl R. Leinbach, Goshen; Robert C. McAdams, Boswell; Henry G. McDullough, Columbus; Camiel C. Mahank, Mishawaka; Richard O. Moore, Washington; Edwin C. Mueller, LaPorte; Raymond L. Newnum, Kingman; Paul Pickett, Jr., Worthington; Kenneth E. Pitts, Overland, Mo.; Benjamin A. Ranck, Fountain City; Richard A. Rhamy, Wabash; Donald C. Smith, Edinburg; Richard A. Snapp, Whiting; John M. Spears, Franklin; Carl F. Stallman, Jr., Auburn; Clarence C. Starr, Seymour; Jesse C. Staten, Greencastle; Albert L. Van Ness, Bloomington, Ill.; John Van Wienen, Three Oaks, Mich.; David G. Wagner, Paoli; Billy D. Wagoner, Butler; William M. Walton, Mt. Vernon; Leonard H. Wiatt, New Palestine; Wilbur W. Wilson, Greenfield.

Deaths

George W. Cline, M.D., of Muncie, died suddenly on July sixth, at Union City. He was thirty-three years of age. He was a graduate of the Indiana University School of Medicine, in 1941. He was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Adam J. Knapp, M.D., of Evansville, died on July ninth at the age of ninety-three. He was a graduate of the University of Tennessee College of Medicine, in Memphis, in 1893. Doctor Knapp retired from practice twenty years ago.

* * *

Calvin E. Carney, M.D., of Delphi, died on July third at the age of seventy-nine. He had been a practicing physician in Delphi for fifty-two years. Doctor Carney was an 1895 graduate of the Medical College of Indiana, in Indianapolis. He was an honorary member of the Carroll County Medical Society, the Indiana State Medical Association, and the Americal Medical Association.

* * *

John M. Jackson, M.D., of Aurora, died at the age of sixty-six on June thirtieth. A graduate of the Medical College of Indiana, in Indianapolis, in 1905, Doctor Jackson began practicing in Aurora in 1913, where he remained until his retirement more than a year ago. A veteran of World War I, Doctor Jackson served for more than two years in the European field. He was a member of the Dearborn-Ohio County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

William J. Solt, M.D., retired physician of San Pierre, died at Gary on August sixteenth, at the age of seventy-seven. He graduated from the College of Physicians and Surgeons of Baltimore, Maryland, in 1896.

* * *

Waldo G. Camp, M.D., of Lynnville, died on August fifth, from injuries suffered in an automobile accident. He was fifty-four years of age. Doctor Camp was a graduate of the Indiana University School of Medicine, in 1929.

Thomas J. Mansfield, M.D., of Muncie, died on July twenty-second at his home. He was eighty-seven years of age. Doctor Mansfield was a graduate of the American Eclectic Medical College, in Cincinnati, in 1890, and had practiced in Delaware County for fifty years.

* * *

Harold F. Dunlap, M.D., of Indianapolis, died on July twenty-second after an illness of several months, at the age of fifty-one. He was a graduate of the Indiana University School of Medicine, in 1920, and had practiced internal medicine in Indianapolis for fourteen years. He was formerly chief of medical service at the Indianapolis City Hospital. Doctor Dunlap had served on many medical society and hospital boards, and during the war was chairman of the medical advisory board of the Indiana Selective Service Commission. He was a fellow of the American College of Physicians, a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Charles E. Cottingham, M.D., of Indianapolis, died at his home on July twenty-third. He was seventy-nine years of age. Doctor Cottingham graduated from the Medical College of Indiana, in Indianapolis, in 1895, and had served in World War I as captain in the medical corps. He was an honorary member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Joseph H. Willis, M.D., of Evansville, died at his home on August sixth, after a long illness. He was seventy-six years of age. He was a graduate of the Hospital College of Medicine of Louisville, Kentucky, in 1897, and had practiced in Evansville for fifty years, specializing in surgery. Doctor Willis was a Fellow of the American College of Surgeons, an honorary member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

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1. *D'Antoni, J. S.: Amebiasis, Recent Concepts of Its Prevalence, Symptomatology, Diagnosis and Treatment, Internat. Clinics 1:100 (March) 1942.*

2. *Manson-Bahr, P.: Some Tropical Diseases in General Practice, Glasgow, M. J. 27:123 (May) 1946.*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

July 20, 1947.

The Council of the Indiana State Medical Association convened for its summer meeting at 10:15 A.M., daylight saving time, Sunday, July 20, 1947, in the Columbia Club, Indianapolis, with Dr. Alfred Ellison, chairman, presiding. Roll call showed the following present:

Members of the Council:

First District—Not represented
Second District—Not represented
Third District—A. P. Hauss, New Albany
Fourth District—C. F. Overpeck, Greensburg
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—Not represented
Eleventh District—C. S. Black, Warren
Twelfth District—Paul A. Garber, South Whitley
Thirteenth District—Alfred Ellison, South Bend

Officers:

Floyd T. Romberger, Lafayette, president
Cleon A. Nafe, Indianapolis, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
N. K. Forster, Hammond, associate editor of THE JOURNAL
C. H. McCaskey, Indianapolis, chairman, Executive Committee
W. L. Portteus, Franklin, member, Executive Committee
Albert Stump, Indianapolis, attorney
Ray E. Smith, Indianapolis, executive secretary

Guests:

Charles F. Thompson, Indianapolis, chairman, Veterans Committee
Thurman B. Rice, Indianapolis, Professor of Bacteriology and Public Health, Indiana University School of Medicine
John D. VanNuys, Indianapolis, dean, Indiana University School of Medicine

On motion of Drs. Mitchell and Hauss, the minutes of the spring meeting of the Council, held at Indianapolis on April 13, 1947, were approved as printed in the June, 1947, issue of THE JOURNAL.

Reports of Councilors

Reports of the councilors on district meetings and activities indicated that all districts are functioning well.

DR. HAUSS reported that the hospital situation in the Third District is going to be improved tremendously by development of plans for new hospitals at Salem, Jasper, New Albany and Corydon.

DR. KENNEDY spoke of "a rather unique thing" that had occurred in his district. "A little community in Henry county wanted a doctor. A committee of the leading citizens was appointed and they made considerable investigation of many men until they found one who met the requirements. They provided a suitable home and office for him and then gave him a community welcome. The medical profession of the county was in large attendance. It struck me as an excellent idea. I think it was the very first public meeting to honor a doctor that I ever went to, that they didn't bury the doctor. It struck me that this community had hit upon a method that might be very helpful in getting doctors to go to the smaller communities."

DR. DODDS read the following resolution, originated by the Clinton County Medical Society and endorsed by the Ninth District Medical Society at its meeting on May 15, 1947:

> "The Clinton County Medical Society hereby declares itself in wholehearted approval of the following:
> "1. That the State Medical Association, in conjunction with the State Board of Medical Registration under the laws of the state be empowered to accredit hospitals for internship within the state.
> "2. That the system of American boards be abandoned except as representing voluntary membership.
> "3. Withdrawal of the American College of Surgeons or other organizations from a position of control of staff membership of any hospital in our state and further, from control of any and all operation procedures within the hospitals of our state, withdrawing to a position of consultations on request and eliminating entirely any taint of compulsion.
> "4. Immediate restoration of the county medical society to the basis of organization of the profession.
> "5. Reaffirmation of adherence to the ethics, morals and dignity of our profession and a determination to deny any and all future movements that lead to any form of compulsion other than the continuance of the high aim that has been our past history."

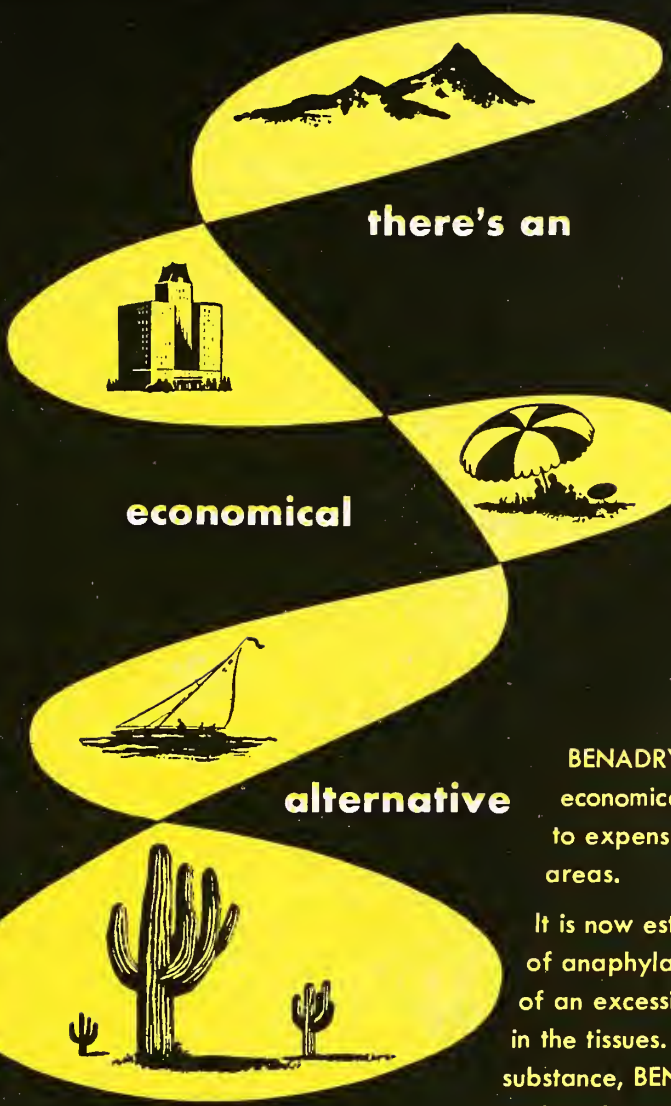
On motion of Drs. Dodds and Mitchell this resolution is to be brought to the attention of the House of Delegates at its meeting on October 28, 1947.

DR. ELLISON reported that one floor (29 beds) of one of the two hospitals in South Bend had been closed because of the shortage of nurses, with little prospect of getting it open soon.

Reports of Officers

DR. ROMBERGER, president: I think that one of the best extemporaneous speeches to which I ever listened was made, on just such an occasion as this, by our good friend and ex-president, Jake Oliphant.

While I do not aspire to such heights, and possibly never could attain them, yet I do feel that I owe this Council information on just a few of the many things which have come to my attention these past months, matters on which I have an opinion, a decided opinion. And, inasmuch as this



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will be the last opportunity that I may have to talk intimately with this Council, because at French Lick I will have many irons in the fire, now seems the appropriate time.

It is a great pleasure to me to be able to report to you that the affairs of state of this great association are moving along quite smoothly. This is not solely because of me. The credit is due to the entire official family. Our membership stands at its very highest. Our financial situation is sound. We have more money in the bank and in bonds than ever before. Those of you who read the committee assignments in THE JOURNAL will notice that a few presidentially-appointed committees have been eliminated and the number of members on many committees has been reduced. This has been done for organizational efficiency. Despite some criticism, it works. All committees, to the best of my knowledge, are very active and functioning well. I feel that our headquarters office has a revitalized efficiency, and I believe all of you who have called on that office for service will agree with me.

All the councilor districts have been visited, but one, this with the able assistance of your president-elect and our executive secretary. That one district had its meeting when the state association officials were in Atlantic City attending the American Medical Association Centennial convention. The enthusiasm of the membership at these meetings was high. The programs were very good; many fine papers, worthy in every respect of being heard at the state level, were read. The men who attended the district meetings were much interested. They stayed awake, were alert, and seemed to want to learn.

In my state-wide travels, I made two very interesting contacts, just a bit out of the ordinary. One happened in our Sixth District, when we met at Richmond. Dentists from all over the state were having an "open-house" demonstration of the so-called Richmond Project. This is a five-year survey or experiment being made by the United States Public Health Department, in co-operation with the Indiana State Dental Association and the City School of Richmond. They are giving free dental care to every school child from the sixth grade up through the twelfth grade. It was exceedingly interesting to see their setup. Personally, I wonder how many, both in the dental and in the medical profession, recognize what the score is; i.e., what might eventuate regarding the implications of such a venture. I think this is a thing which this Council and our great State Association should watch and follow very, very closely.

The second quite interesting contact I had was when I spoke at the dedication of the Johnson County Memorial hospital, in Franklin. Here is a county which had been denied federal aid, yet of their own initiative, their own effort, and their own money, they went out and built themselves a very fine hospital, modern to the nth degree. It is a marvelous tribute to the good people of Johnson county. It is a true expression of the Jeffersonian principles of democracy, doing for your own selves that which to yourselves pertains. The citizenry of Johnson county is to be congratulated and the profession of Johnson county is to be congratulated on its magnificent effort.

With reference to the county societies, I would like to see every delegate elected to the House of Delegates come there in October instructed on the wishes of his society. I think he should be impressed with the necessity of being there, faithful to the trust confided in him by his society. I find that some county societies pay and others do not pay the expenses of their delegates to the state convention. I believe, from my own experience in my own county, it would add to our organizational strength if the councilors would advise their county societies to pay their delegates' expenses to the state convention. The society then would have a vested interest in his services, and he the same in reporting back to his society. Many times I have sat in our House with only 50 to 60 per cent attendance. The affairs of state of this great association cannot be conducted rightly in such a manner, with true justice to all from a united opinion and effort.

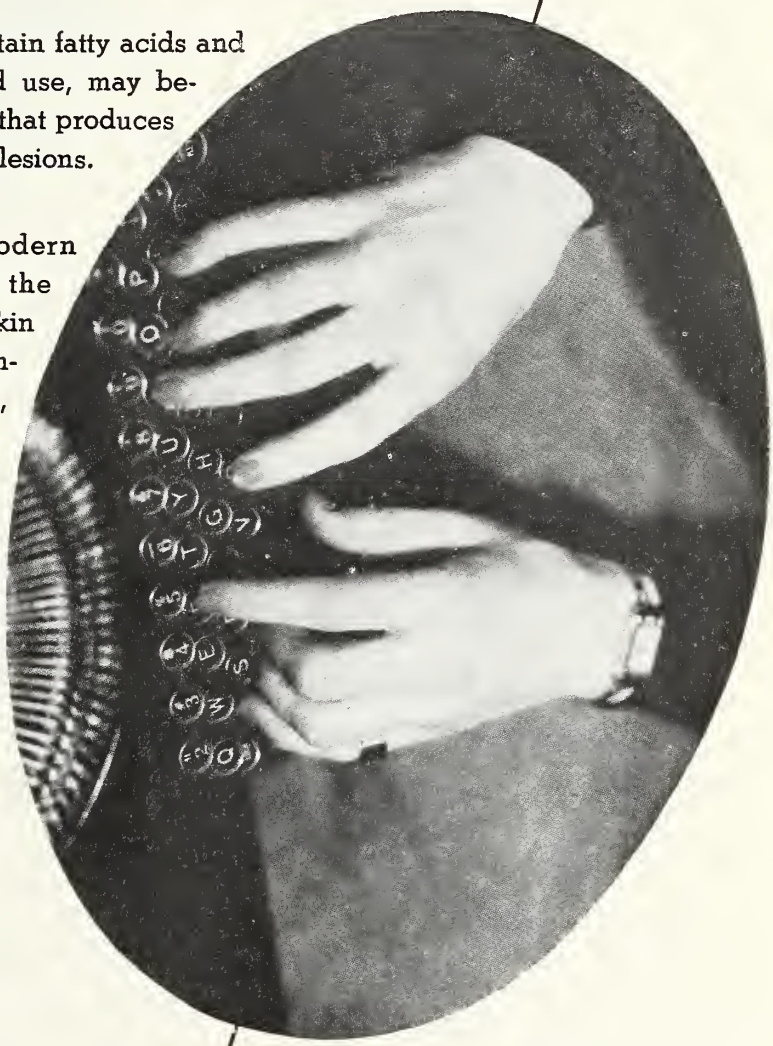
To my great surprise, although I had no yardstick by which to measure it, I found that more than one of the district meetings was very poorly attended. I do not believe that the district society is outmoded. I believe that each district has its own problems that are indigenous to its district. Upon the organized strength of the counties and districts depends the future vigor of the state association.

I think this Council is to be very highly commended on its Scholarship Trust. It has received nice publicity throughout the state. Due to the wise provisions of this trust, as organized by the committee which was headed by Dr. Clark, it is an open end trust; i.e., it is open at one end to receive funds and open at the other end to spend funds. I am happy to report to you that a childless couple in Lafayette has signed identical wills, assigning the income from their property, when it becomes an estate, to this scholarship trust.

A few words about our headquarters. Our headquarters offices down here are very shabby. I don't know, neither do I advise, what sum of money should be spent; that is the province of the Council. But, this I do know; compared with other business places and in contrast with a great many of the doctors' offices, our place looks and feels depressing when you go into it. More and more as the years go on, our headquarters is in contact with many allied bodies at the state level, and our present setup there is not a good advertisement for the great Indiana State Medical Association. I think, myself, that we should have our own building. We have the money; cash in bank, bonds in general fund $31,000, bonds of medical

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defense fund $15,000, in all a total exceeding ninety thousand of net worth. Surely we at least can start with this. I believe that we ought no longer hestitate to approach this and have for ourselves, for the great Indiana State Medical Association, a real place, one which will be a credit to our association.

A few words about Atlantic City. One of the things which was featured down there was the state presidents' conference. This was the third conference. Two or three years ago when they first proposed this, I thought it undemocratic; and I am still of that opinion. It is an undemocratic and sterile sort of thing; nothing came out of it; largely because they have set it up as a conference of presidents, ex-presidents, secretaries, and executive secretaries. Over a thousand are eligible. Only the current presidents are elected. The remainder are nonelective, hence nonrepresentative of the great body of physicians. Besides, the conference has no power or influence whatsoever.

Frankly, I attended this conference largely to confirm a previous opinion and to hear Senator Taft. He impressed me as having a brilliant mind. Yet, the best that I could figure from his address was that it was a political speech. He condemned the Murray-Wagner-Dingell bill and praised his own. To me, that's politics. He had no solution. He admitted that nobody could figure either the costs or the future implications, professionally. I therefore still hold to previously announced belief: Both bills would cut our professional throats, severing the head from the corpus; the one by a single, razor-keen, fell stroke across the jugulars and the windpipe; the Taft bill by slow dissection.

Dr. Nafe, president-elect, asked the councilors for suggestions for committee appointments for 1948. He also spoke of the Conference on Medical Service of the A.M.A., at which the following subjects were discussed:

(1) Are enough doctors being graduated?
(2) Are there sufficient medical schools?
(3) Are the pre-medical and early years of medical education too strenuous?

"Out of 128 students in our school, 31 have fallen by the wayside already. We should work very hard next year to get the first year of medical school moved to Indianapolis. We should try to implement our various resolutions to get the first year here, and remedy the situation by eliminating this large first-year failure. If what Parran says is true, that is, by 1950 we will need 30,000 more doctors, the medical profession is going to be on the spot." Discussed by Drs. Ellison, McCaskey and Hauss.

Dr. Hauss: I am wondering if our public policy committee is going to make a recommendation in regard to this problem to the House of Delegates or if we should have a specially appointed committee to bring in a definite report to the House of Delegates. After the House of Delegates discusses it, the House could make its recommendations to the A.M.A. All of these things have to be carried to the national level if anything is accomplished. A recommendation should be made as a result of study. It will have a better chance of going forward than by just discussing it here.

I am not in favor of lowering the standards of medical education but I do believe we have tightened up at the wrong end of the curriculum. If you will make it a little easier to become a general practitioner and then tighten up on what it takes to make a specialist, you will increase the number of general practitioners, decrease the number of specialists and have more doctors to serve the public.

Dr. Hauss made the motion "that the Council authorize the appointment of a committee to consider recommendations on undergraduate medical education and that this committee bring definite recommendations to the House of Delegates in October." Motion seconded by Dr. Black, and passed.

Dr. Weyerbacher, treasurer, announced that the Auditing Committee had held its annual meeting on July 16 and its report showed that investments of the association total $46,000.00 and cash on hand in all funds as of June 30, 1947, amounts to $46,457.30, making the total assets of the association at this time $92,457.30. He said, "Of course, it must be realized that our cash balance will gradually be consumed by the end of the year. The only possible increase will come from the sale of exhibit space at the French Lick meeting."

Dr. Forster, associate editor of The Journal: I have a brief report on Journal finances in which you might be interested. The Cooperative Medical Advertising Bureau is remitting our advertising revenue by the month now instead of letting it accumulate and sending it to us in a lump sum at the end of the year. Due to this fact, and because of economical operation, The Journal bank balance, as of June 30, was $10,211.36. Despite increased printing costs, our total expenses for the first six months of 1947 are only $1,514.00 more than for the same period in 1946. Payroll expense has been reduced by $431.00 for the first six months of this year as against the same period last year because we have operated with one less person and less part-time help. This reflects better management under Mrs. Rowlison. This saving was accomplished in spite of increases in salaries of The Journal personnel. I would like to take this opportunity to say that we certainly would appreciate any suggestions that the Council, which after all is the governing board of The Journal, might care to make as a body or as individuals for improvement in the general make-up of The Journal.

(Continued on page 914)



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Dr. McCaskey, chairman of the Executive Committee, spoke on the following matters which were referred to the Council by the Executive Committee:

1. *Provision of postgradute instruction by the Indiana State Medical Association to county and district societies.* The Committee on Public Relations held a meeting on July 13, 1947, with the following members present: W. D. Gatch, chairman; J. E. Ferrell; Norman R. Booher; Rollis S. Weesner; and Ray E. Smith. Dr. Gatch's report follows:

"The Council had asked our committee to make a study of this matter. The chairman and Mr. Smith decided that the study would be greatly helped if we could determine the desire of the physicians of the state for postgraduate instruction. We therefore sent out a questionnaire to the secretaries of the county and district societies asking for information on:

"(1) Whether or not they desired instruction;

"(2) Whether or not they wished it given at regularly scheduled meetings;

"(3) How far did they think their members would be willing to go to meetings.

"There was a good return of these questionnaires. Nearly all the secretaries wanted the instruction and wanted it given at regularly scheduled meetings. Most of them wanted it given as near home as possible, at least in their own districts. Very few wanted it given at Indianapolis.

"This is what one would expect to get from the secretaries and does not prove that the physicians of the state are eager for instruction.

"The committee discussed the subject at length and all agreed that nearly all attempts to give postgraduate instruction in the past had been failures—often humiliating failures. The members also agreed as to the reasons for these failures, chief of which are:

"(1) A poor method of instruction—almost entirely by lecture.

"(2) Lack of continuity in program.

"(3) Lack of any possible method of determining what the students had learned.

"(4) Discouraging lack of interest.

"Our attempts at instruction have ignored the first principle of education, namely, that the student must educate himself.

"The committee was of the opinion that—

"(1) To devise and put in operation an effective system of postgraduate instruction would require time and the expenditure of very large amounts of money.

"(2) That centers of postgraduate instruction should be established in various parts of the state, in well-equipped hospitals where continuous courses similar to those given at St. Elizabeth's Hospital, Lafayette, could be given.

"(3) That as an interim measure the association should prepare a list of speakers and a list of subjects for the benefit of county and district secretaries; the speakers not to be limited to physicians, and the subjects not entirely to medical subjects.

"(4) That the association do whatever it can to aid the establishment of good medical libraries in various teaching centers of the state.

"(5) That the association correlate its postgraduate work with that of the Indiana Board of General Practice of Medicine."

Following discussion by Drs. Hauss, Clark, Garber, and Nafe, on motion of Dr. Mitchell and Clark, the report was adopted by the Council.

2. *Meeting of ex-servicemen during the French Lick session.* A luncheon meeting for ex-servicemen will be held at 12 o'clock on Wednesday, October 29, in the Bamboo room of the French Lick Springs Hotel.

3. *Recognition of physicians who have been in practice for fifty years or more.* The Executive Committee proposes that the state association recognize physicians who have been in practice for fifty years or more by presenting them with a lapel button and a Certificate of Distinction at the annual dinner at French Lick in October, and at the same time each succeeding year. The county medical society secretaries are to be asked to designate the physicians who are eligible to receive this honor. On motion of Drs. Clark and Mitchell the Council approved this proposal.

4. *Cancer control program of the State Board of Health.* The Executive Committee voted to recommend to the Council that it approve a three-point cancer program of the State Board of Health as follows:

(1) Education of the laity.

(2) Education of the medical profession in new developments in cancer diagnosis and treatment.

(3) Establishment of a cancer registry.

The Executive Committee did not approve of the establishment of a clinic. The Executive Committee's recommendation was adopted on the motion of Drs. Mitchell and Clark.

5. *Hospital construction program of the State Board of Health with Hill-Burton funds.* Dr. McCaskey read the following report which the Committee on Medical Education and Hospitals had submitted to the Executive Committee:

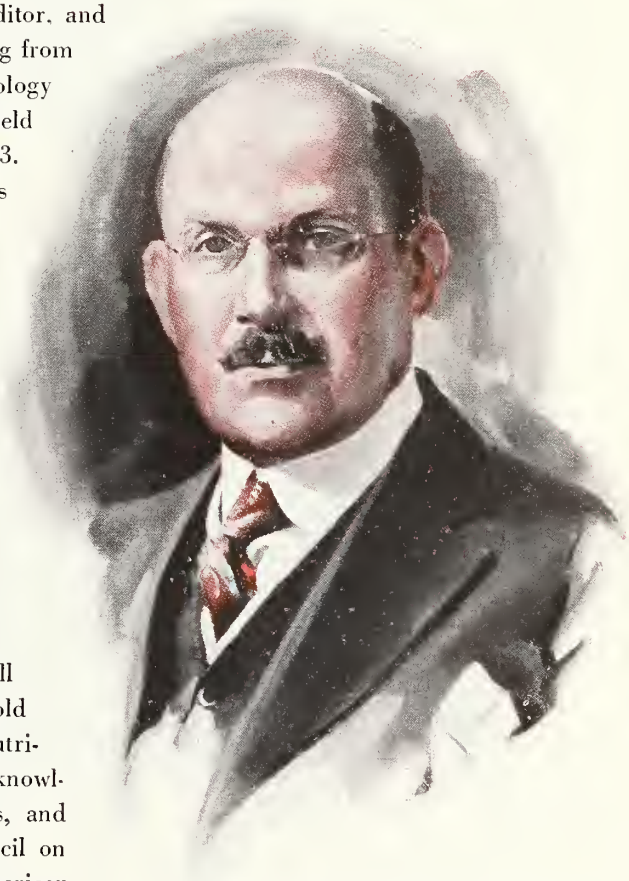
"Relative to the hospital expansion plan set out by and to be implemented by the State Board of Health in conjunction with the Hill-Burton Act, S. 725, we feel that at the outset a few notes of warning should be sounded.

(Continued on page 916)

Men and Amino Acids

Lafayette B. Mendel is recognized as a pioneer in the science of nutrition, and as a writer, editor, and educator of wide influence. On graduating from Yale University in 1891, he studied physiology and physiological chemistry in the Sheffield Scientific School, receiving his Ph.D. in 1893. In 1895 and 1896, he continued his studies abroad under Professor Heidenhain at Breslau, and Professor Baumann at Freiburg. Beginning as an assistant in physiological chemistry at Sheffield, Mendel became a full professor in 1903, and a member of the Governing Board. In 1921 he was named Sterling professor.

For many years, Mendel collaborated with the distinguished investigator of vegetable proteins, Thomas B. Osborne, conducting valuable researches on the comparative biologic value of proteins of differing amino acid composition, as well as in other fields of nutrition. His manifold contributions to our understanding of nutrition in the chemistry of life were acknowledged in numerous lectureships, honors, and awards. He was a member of the Council on Pharmacy and Chemistry of the American Medical Association from 1917 until the time of his death, and of the Committee on Foods from its inception.



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"1. It is our conviction that in the past there has never been nor should there ever be any major disagreement between the private practice of medicine and the maintenance of the public health services by legally constituted authority.

"2. The possibility of bureaucratic control over the private practice of medicine should be duly considered.

"3. Since general medical practice is the backbone of medical service, due consideration should be given this group.

"In view of the crying need for more hospital beds in this state, and because of the rather general expression of preference for this plan over those previously proposed, we recommend its acceptance by the Indiana State Medical Association.

(Signed) EDWIN N. KIME, Chairman,
C. J. CLARK,
O. O. ALEXANDER,
Members present at meeting."

(Endorsed also in principle by letters from Drs. Herman M. Baker, Harry P. Ross and H. E. Klepinger).

This was discussed by Drs. Clark and Mitchell, and upon their motion the report was accepted by the Council.

6. *Survey on rural medical needs.* The suggestion that the county agricultural agents be contacted regarding the opinion of farm people as to whether or not they are receiving adequate medical service was discussed, but no action was taken.

Unfinished Business

1. *Medical Care of Veterans.* Dr. Charles F. Thompson, chairman of the Veterans Committee, reported that since the last meeting of the Council his committee had signed a renewal of the agreement with the Veterans Administration covering the period July 1, 1947, to June 30, 1948. This agreement is on an annual basis and can be canceled at any time.

Dr. Thompson also reported that under the agreement with the Veterans Administration the state association is obligated to submit a list of specialists from its membership. As yet this has not been done. The standard for specialists, not including neuropsychiatrists, as promulgated by the Veterans Administration, are:

(1) Certification by the appropriate Specialty Board; or in lieu thereof

(2) Specialists not possessing Specialty Board certificates—

a. At least four years' experience in a given specialty (including recognized residency), and

b. At least 50 per cent of practice devoted to a certain specialty, and

c. Recognized as specialist by the Medical Association or Society in the State in which he practices.

The method to be used in obtaining this list was discussed by Drs. Mitchell, Hauss, Nafe, Black, McCaskey, Clark, and Forster. Dr. Hauss made the motion "that by order of the Council our state headquarters request the president of each county society to appoint a committee to submit a classification of the membership in each county, in accordance with the qualifications set forth in the Veterans Administration request, and that the president of the state medical association appoint a statewide committee to correlate and classify these reports. This is to be done regardless of what information the American Medical Association can supply." This motion was seconded by Dr. Clark, and passed.

2. *Mutual Medical Insurance, Inc.* DR. KENNEDY reported: The company is going along very satisfactorily, so much so that I think no other similar organization has progressed quite so rapidly as we have during the past ten months. The increasing support and loyalty of doctors to the plan is very reassuring. We have something over 100,000 subscribers. Our income presently is running at the rate of three-quarters of a million dollars per year. Our assets now are in excess of $300,000, with ample surplus. We are just beginning to get the impact of the expiration of certain waiting periods. In two months our bill for tonsillectomies was $10,000.00. The next thing we will have to meet will be the matter of obstetrical service, and the obstetrical rate is exceedingly high in Indiana, 32 per thousand.

3. *Committee for the Study of Nursing Service.* DR. CLARK, chairman, reported:

(1) That the committee had met with representatives of the Indiana State Nurses' Association and the Indiana Hospital Association on July 13, at which time the committee was told of the drive by the local Junior Chamber of Commerce, to start August 3, to help secure candidates for nurses' training. The Junior Chamber of Commerce has agreed to put on this drive on a state- and nation-wide scale through their various organizations. The Junior Chamber has fifty-three or fifty-four chapters in the state of Indiana. A pamphlet containing all of the pertinent facts about entrance requirements of the Indiana nursing schools has been compiled with the assistance of the State Nurses' Association. The State Nurses' Association will pay one-half of the cost of printing this pamphlet and the state medical association the other half. One of these booklets is to be placed in the hands of every high school principal and in every school library in the state in order to make the information available to the girls before it is too late. This will cost the state association approximately $300.00. On motion of Drs. Clark and Mitchell, the Coun-



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cil approved of the necessary expenditure in having this booklet printed.

(2) That this committee recommends that each county society have an advisory committee to help, aid, and assist girls who might want to enter nurses' training, if only as much as to tell them where to go to get information that that committee might not have.

(3) That his committee recommends that six scholarships at $200.00 each be provided each year by the Indiana State Medical Association for girls entering nurses' training, to help defray the cost of tuition.

Dr. Clark made the motion "that the Indiana State Medical Association provide six $200.00 scholarships a year for a total of not more than $1,200.00 a year, to girls entering nurses' training, these scholarships to be handled preferably in conjunction with the medical school scholarships and be open for outside donations." Motion seconded by Dr. Black, discussed by Drs. Dodds, Nafe, Forster, and Hauss, and passed.

Dr. Clark suggested that this matter be handled in the following order:

(1) Publicity

(2) Prepare trust agreement

(3) Nursing Committee and Scholarship Committee to serve as a joint committee to work out details.

On motion of Drs. Mitchell and Dodds the Council approved of the Committee on Medical School Scholarships handling both medical and nursing school scholarships.

(4) That the committee recommends that the Woman's Auxiliary be asked to co-operate with this committee in the enrollment drive.

(5) That the committee recommends the wholehearted support of the report of the joint committee of the Indiana State Nurses' Association and the Indiana Hospital Association, which was accepted unanimously by both of these groups. If the doctors are cognizant of the contents of the report and see that their hospitals are living up to the terms of it, that in itself will aid materially some of the nursing problems, Dr. Clark said.

(6) *Nursing school tuition fees.* The committee feels that the schools are getting a considerable amount of work out of their second- and third-year students and they should make some provision to recompense these students. Dr. Clark said the Indiana Hospital Association is going to compile some figures on time and cost of service from the standpoint of the hospitals and also their training costs, and will have that information for his committee soon. He suggested that the state legislature could subsidize these training schools and in that way eliminate the cost of training to students.

(7) That the mechanism is set up whereby any medical installation that does not have an accredited training school can apply for an accredited practical nurses' training school. The State Nursing Board is permitted by law to license these nurses but there hasn't been any application made for establishing one of these schools. It might be possible at the state meeting to stimulate the interest of the doctors to carry this thought back to their local hospitals where they do not have training schools. Through the State Nursing Board they can learn what is necessary to establish requirements for training practical nurses.

4. *Report of Scholarship Committee.* Dr. Clark, chairman, reported that eighteen inquiries had been received and to date three students have made definite application, all of whom apparently are financially in need of help. Many inquiries came from persons ineligible to receive scholarships. Pamphlets explaining the scholarships and application blanks have been distributed to all colleges accredited for premedical training.

5. *Establishment of Bureau of Information in the Department of Public Health of Indiana University School of Medicine.* Dr. Thurman B. Rice, professor of Public Health, Indiana University School of Medicine, presented the following report to the Council:

Members of the Council of the Indiana
State Medical Association:

Gentlemen:

Some weeks ago I spoke to you about setting up a bureau in my department at the University for the purpose of more completely utilizing health and vital statistics. I wish at this time to present the matter in a more carefully thought out form.

1. The name to be given this organization is Bureau of Information, it being understood that the scope of the information offered is to be statistical.

2. In so far as the information offered is related to the medical profession in its scope, I should like to have the Bureau operate under the surveillance of an Advisory Committee of at least three physicians. A similar courtesy will be extended to other professional groups whose problems may be considered (dentists, veterinarians, nurses, etc.).

3. The work will begin about September 1, with one statistical clerk. Enlargement of the program will be determined by need and the availability of funds. Some months will elapse before we shall be able to show results.

4. The following projects will be undertaken, subject to the approval of the professional advisory council concerned:

A. Furnish statistical information of any sort within our range to professional individuals and groups wishing to use such information for any legitimate health or professional purpose. This service will also include the checking of

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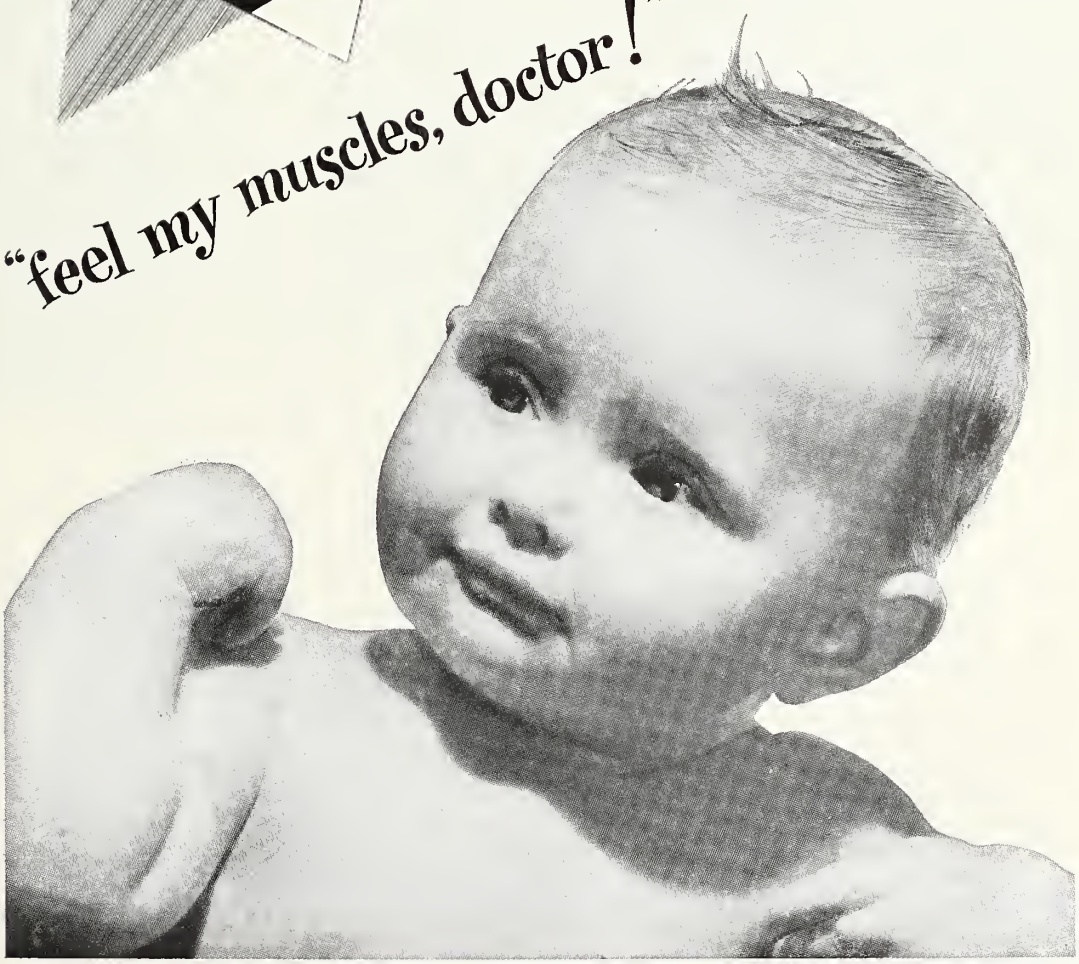
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data used in papers published or to be published when such a service shall be requested.

B. Assistance in the preparation of sound quota lists (Cancer Society, Red Cross, Tuberculosis Association, Community Chests, Crippled Children and Poliomyelitis drives) when requested by the society concerned.

C. Studies on the distribution of physicians, medical specialists, dentists, veterinarians, nurses and other professional groups, provided such studies are requested or approved by the Advisory Committee of the profession concerned.

D. Compilation of information concerning each of the counties and communities of the State to the end that professional persons may be able quickly to decide whether such a community is a suitable one for the establishment of a practice.

E. A study of the various environmental, economic, sociological and industrial factors which determine the existence of the distribution of disease in the State of Indiana, and in Indiana as associated with other states.

F. The preparation of a large study entitled "Fifty Years of Vital Statistics in Indiana." This study cannot be completed before the year 1952, but much of the preliminary work can be done now and can be accumulating.

G. The preparation of graphs, maps, charts, and models to be used in graduate and undergraduate instruction, and for display at medical and health meetings of all sorts.

H. The publication of statistical material on matters related to health in professional journals, the *Bulletin of the State Board of Health*, newspapers and magazines, provided that the material is not to be commercialized in any way.

I. Furnish information which may be requested by the Legislature, Legislative committees and other such groups as may help in the passage of sound legislative matters pertaining to health and professional practice.

J. This program is dedicated to the best interests of the Indiana public and the professional groups concerned. As other needs in this direction arise new projects will be undertaken, subject, of course, to approval by the professional group concerned.

It is specifically understood that this organization is to furnish information only. It is not to give advice, exert political pressure, or take part in controversies except as the furnishing of unbiased data to such persons or groups, upon request, may affect decisions and exert influence. It is not to furnish information for commercial firms except as they may see fit to use data prepared for other purposes, such data to be used exactly as released and with proper acknowledgment.

We believe that this information can go a long way toward helping the people and the profession to make wise choices in matters pertaining to health and professional practice. It is in line with an effort being made by the American Medical Association on a national level.

We very respectfully request the approval of the Council.

On motion of Drs. Kennedy and Mitchell, Dr. Rice's project was approved by the Council.

6. *Management of nursing homes.* MR. STUMP, attorney for the association, said that under the law passed at the 1947 session of the legislature any person who accepts three or more persons to care for in her or his home is considered operating a nursing home and must have a license issued by the State Department of Public Welfare. The home must be inspected annually by the Welfare Department, the State Board of Health, and the fire marshal. The rather lengthy rules and regulations governing the operation of these institutions have been adopted tentatively by the Department of Public Welfare. There is nothing to indicate that the rules as now in effect will not be approved. They have been approved by the State Board of Health and the attorney general. They have to do with the matter of medical care necessary, furnishing of food, and keeping the premises in order. There is nothing in the rules and regulations that is unfavorable to the medical profession.

Indiana University School of Medicine

DR. JOHN D. VAN NUYS, dean of Indiana University School of Medicine, was a luncheon guest and spoke of some of the problems confronting the school at this time. He was extended an invitation and will appear before the House of Delegates at French Lick on October 28.

1947 (98th) Annual Session at French Lick, Tuesday, Wednesday and Thursday, October 28, 29, 30, 1947

DR. HAUSS, co-chairman of the Convention Arrangements Committee, reported that he had made four trips to French Lick to confer with the manager of the French Lick Springs Hotel on arrangements for the "whale of a convention" which is to be held on October 28, 29 and 30. The hotel management is very co-operative, Dr. Hauss said, and has assured him that everything will be in readiness for the annual session of the association.

Dr. Hauss asked the Council on what basis those not registered at the French Lick Springs Hotel should be admitted to the frolic and dinner to be held on Tuesday evening, October 28. On motion of Drs. Garber and Clark the Council approved admitting the exhibitors as guests of the association and charging all others who come from the outside the regular dinner charge of $2.50.

Legislative Matters

Mr. Smith, executive secretary, reported on the status of the Wagner-Murray-Dingell bill (S. 1320), the Taft bill (S. 545), and the Fullbright-Taft bill (S. 140), now pending in Congress.

(Continued on page 922)



WELL TOLERATED by the NEWBORN

Clinical experience establishes that CARTOSE* is especially well tolerated by newborn infants.

CARTOSE supplies carefully balanced amounts of non-fermentable dextrins, with maltose and dextrose. These offer the advantages of: spaced absorption because of the time required for hydrolysis of the higher sugars ; less likelihood of distress due to the presence of excessive amounts of fermentable sugars in the intestinal tract at one time.

CARTOSE is liquid; formula preparation is simple, rapid, and accurate. It is compatible with any formula base: fluid, evaporated, or dried milk.

*The word CARTOSE is a registered trademark of H. W. Kinney and Sons, Inc.

ACCEPTED AMERICAN MEDICAL ASSN

CARTOSE
REG. U. S. PAT. OFF.
Mixed Carbohydrates

H. W. KINNEY & SONS, INC. — Kinney trademark — COLUMBUS, INDIANA

New Business

1. *Medical Ethics.* Dr. Portteus, member of the Executive Committee, presented a resolution concerning medical ethics, which he had drawn up at the request of the Executive Committee, for the thought and consideration of the Council. This resolution is to be brought to the attention of the Council at its next meeting.

2. *Scholarship awards to medical students.* Dr. Clark, in a motion, proposed that the Indiana State Medical Association "do a little good will work with the medical students by presenting to the three men highest in scholarship in the senior class a small watch key award." The cost for the original die would be $37.50 and the keys would cost $20.00 each year. This motion was seconded by Dr. Black, and passed.

There being no further business, the Council adjourned, to meet again at 12:30 P.M. on Tuesday, October 28, at the French Lick Springs Hotel, French Lick, Indiana.

RAY E. SMITH,
Executive Secretary.

EXECUTIVE COMMITTEE

July 19, 1947.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; Floyd T. Romberger, M.D.; Cleon A. Nafe, M.D.; Alfred Ellison, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; and Ray E. Smith, executive secretary.

Guests: E. N. Kime, M.D., chairman, Committee on Medical Education and Hospitals; W. D. Gatch, M.D., chairman, Committee on Public Relations; H. C. Ochsner, M.D., president, Indiana Roentgen Society; C. A. Stayton, M.D., chairman, Committee on Control of Cancer; L. E. Burney, M.D., State Health Commissioner.

Membership Report

Number of members July 19, 1947	3,542*
Number of members July 19, 1946	3,406
Gain over last year	136
Number of members December 31, 1946	3,509

* Includes 116 in military service (gratis)
172 honorary members

Treasurer's Office

The treasurer reported that the Auditing Committee had met on July 16, 1947.

Loans to veterans. Loan of $500 to veteran approved by consent. The committee went on record that in the future loans should be made only to members of the Indiana State Medical Association, regardless of where the veteran intends to practice.

Statements of receipts and expenditures for May and June for the Association committees and THE JOURNAL were approved.

1947 Annual Session, French Lick, October 28, 29, 30, 1947

Program:

a. Banquet.
 1. The principal speaker is to be limited to thirty minutes.
 2. Thomas Collins of Kansas City is to be the second speaker and banquet entertainer.

b. The question of a servicemen's luncheon was referred to the Council.

Presidents' dinner. On motion of Drs. Romberger and Nafe, the question of holding a presidents' dinner was postponed indefinitely.

Distribution of applications for membership in American Academy of General Practice. Request of the director of the American Academy of General Practice for permission to distribute application blanks at the annual session was referred to the Indiana Board of General Practice of Medicine for approval. Question to come before committee at next meeting.

Badges. On motion of Drs. Ellison and Romberger, the executive secretary was authorized to select what he thought would be an appropriate badge.

Bodily injury liability insurance. It was voted on motion of Drs. Romberger and Nafe to subscribe for bodily injury liability insurance, $10,000/$100,000 coverage for six days, the same as carried in 1946.

Bartholomew-Brown County Medical Society. The committee ruled that inasmuch as Brown county has no members, the Bartholomew-Brown County Medical Society is entitled to only one delegate in the 1947 House of Delegates.

Annual report of Executive Committee. On motion of Drs. Nafe and Romberger, the chairman and executive secretary were directed to prepare the annual report of the Executive Committee to the House of Delegates.

Legislative Matters

National

Shearon Medical Legislative Service. On motion of Drs. Portteus and Ellison, the committee authorized subscribing to the Shearon Medical Legislative Service for five copies of its weekly news release.

Taft bill, S. 545. Status of this bill explained by the executive secretary.

Difference between the former and present Wagner-Murray-Dingell bills discussed by the attorney.

(Continued on page 924)

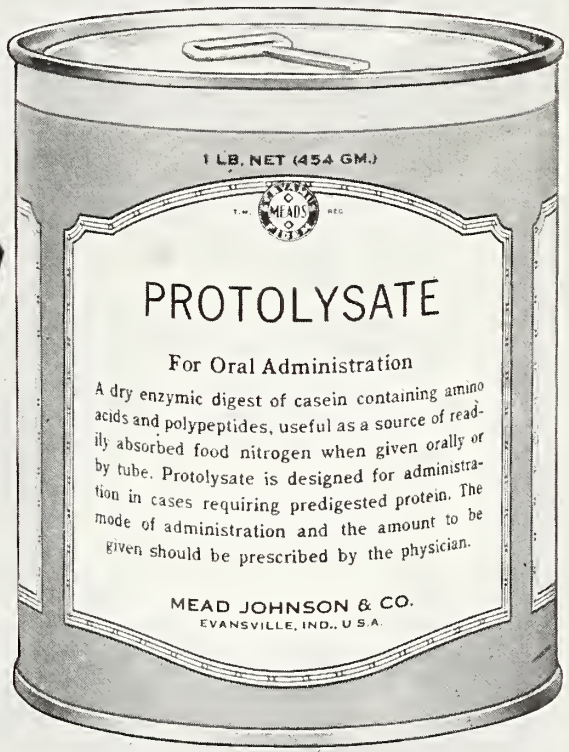
1000 cc. flasks
500 cc. flasks
125 cc. flasks
for hospitals.



COUNCIL-ACCEPTED
AMIGEN
for parenteral administration of amino acids

The function of Amigen and Protolysate is to supply the amino acids essential for nutrition. Both can be given in place of protein when protein cannot be eaten or digested, or in addition to protein when the protein intake is insufficient. Administered in adequate amounts, they prevent wastage of protein, restore previous losses, or build up new body protein.

COUNCIL-ACCEPTED
PROTOLYSATE
for oral and tube feeding of amino acids



Like Amigen, Protolysate is an enzymic digest of casein and consists of amino acids and polypeptides. Like Amigen, Protolysate supplies the nitrogen essential for maintenance, repair and growth.

Unlike Amigen, which may be employed both orally and parenterally, Protolysate is designed only for oral use.

1 lb. cans at drug stores

MEAD JOHNSON & CO., EVANSVILLE 21, INDIANA

There is no shortage now of AMIGEN for parenteral use. There is no shortage now of PROTOLYSATE for oral use.

The executive secretary was directed to write the Louisiana State Medical Society for specific information as to why it is objecting to the appointment of A. W. Dent on the Federal Hospital Council. The Executive Committee deferred action pending receipt of this information.

Organization Matters

Fifty-year Club. Upon motion of Drs. Nafe and Ellison it was decided to organize a fifty-year club, composed of physicians who have practiced medicine for fifty years or more and who are recommended for this honor by the county medical societies, if it meets with the approval of the Council. The members of the fifty-year club are to be presented appropriate pins and framed certificates at the annual dinner meeting of the association.

Rules governing membership in Fifty-year Club.

a. Only physicians recommended by the county medical societies will be eligible to receive this recognition. The state headquarters is to contact each county medical society secretary for certification of eligible physicians.

b. Date of graduation from medical school is to be considered the beginning date of practice.

Appointment of Dillon Geiger, M.D., as trustee of Indiana University. The chairman of the Executive Committee is to send a letter to the Governor expressing the thanks of the association for the appointment of Dr. Geiger.

Membership in Hoosier State Press Association, Inc. This membership, at $12.50 per year, was approved by consent.

Moving of first year of medical school to Indianapolis. The attorney reported that he had mailed the letter to the president of the University and the president of the Board of Trustees in accordance with the Executive Committee's request.

The committee reaffirmed the following resolution, which was adopted by the House of Delegates at its October 31, 1946, meeting:

"WHEREAS, The Indiana University School of Medicine is divided in location with the first year at Bloomington and the remaining three years at Indianapolis; and

"WHEREAS, This division is not conducive to the best of medical training; and

"WHEREAS, Students of the first year miss a great amount of medical atmosphere and the correlation of basic science with clinical conditions; and

"WHEREAS, Students of the remaining three years do not have the opportunities of reviewing basic sciences or serving as assistants in the various basic sciences; and

"WHEREAS, Better teaching facilities could be secured and made available to undergraduates, postgraduates and graduates in medicine; therefore

"Resolved, That the Indiana State Medical Association go on record of favoring the moving of the first year of medicine to the Medical Center at Indianapolis as soon as is possible.

"Resolved, That the Medical Center be placed under its own supervision and own budget that it may then be able to secure the best of medical talent for teaching.

"Resolved, That a copy of this resolution be forwarded to each trustee of Indiana University."

Vanderburgh County to employ full-time secretary. Report made that the Vanderburgh County Medical Society soon will have a full-time executive secretary.

Notification of physicians about August 31 deadline for paying annual registration fee. All physicians who have not paid their registration fee by August 1 are to be notified by the headquarters office of the state association. In the event that such a list is not available, all members of the association are to receive a postal card reminder. This was done on motion of Drs. Nafe and Romberger.

Postgraduate Study

Report on the study made by the Committee on Public Relations referred to the Council on motion of Drs. Nafe and Portteus.

Cancer Control Program of State Board of Health

Drs. Burney, Stayton and Ochsner appeared before the committee and discussed the cancer control program of the State Board of Health.

On motion of Drs. Nafe and Portteus, the committee voted to recommend to the Council that it approve a three-point cancer program of the State Board of Health as follows:

1. Education of the laity.
2. Education of the medical profession in new developments in cancer diagnosis and treatment.
3. Establishment of a cancer registry.

Dr. Stayton, chairman of the Committee on Control of Cancer, reported that the Indiana Cancer Society had voted to employ a full-time physician as executive vice-president, as recommended by the Executive Committee of the Indiana State Medical Association. He also reported on other actions of the State Cancer Society.

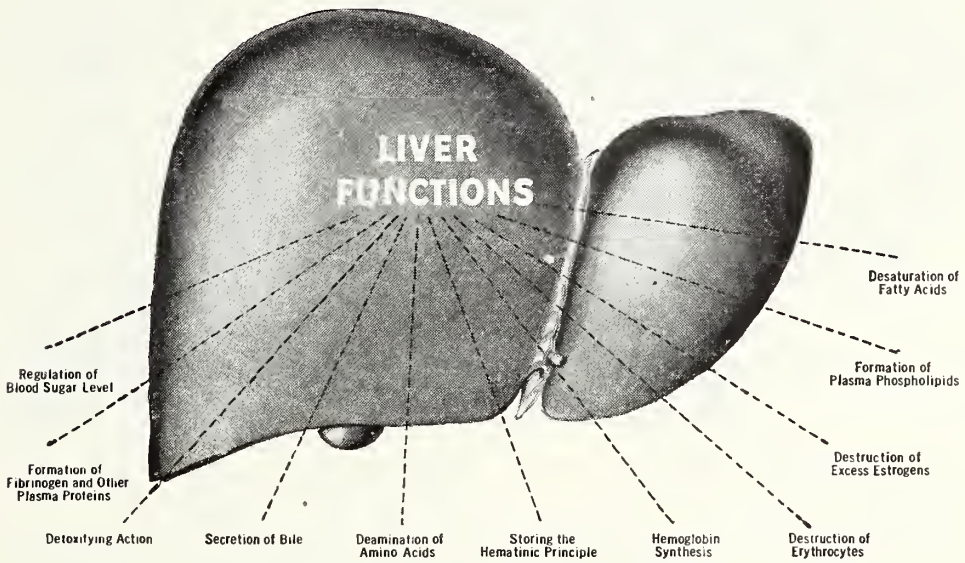
Proposed Indiana Hospital and Health Center Program, State Board of Health

The report of the Committee on Medical Education and Hospitals, approving the hospital construction program of the State Board of Health, presented by Dr. Kime, chairman of the committee, was accepted and referred to the Council upon motion of Drs. Romberger and Portteus.

Medical Economics

Complaint regarding excessive medical fee. Letter referred to the headquarters office by the Council on Medical Service of the American Medical Association was discussed by the committee and the secretary was directed to send it to the Montgomery County Medical Society for action.

(Continued on page 926)



To Guard the Functional Integrity of the **LIVER**

The complex nature of the manifold functions of the liver is reflected in the diagram shown above. To maintain its functions in an efficient manner, the liver must be adequately protected against toxic influences. Parenchymatous damage with ensuing decreased functional capacity can lead to severe metabolic derangements.

Protein deficiency is an important factor in precipitating impaired liver function. Hence an adequate intake of biologically complete protein, ordinarily in the form of protein foods, is indispensable as a safeguard of liver competency.

Among man's protein foods, meat ranks high not only because of its generous content of protein, but also because its protein is complete, capable of satisfying all protein requirements. Furthermore, all meat is 96 to 98 per cent digestible.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

Complaint against Continental Casualty Company. Following discussion by the attorney of the association, on motion of Drs. Ellison and Nafe the Continental Casualty Company is to be denied advertising space in future issues of THE JOURNAL.

Health and accident insurance policies of other state medical associations. The matter of the association entering into a contract for a group health and accident insurance policy for its membership was discussed.

Rural Medical Service

Suggested letter asking county agricultural agents about medical service situation in their respective counties referred to the Council.

Headquarters Office

Question of refurnishing headquarters and JOURNAL offices postponed on motion of Drs. Nafe and Portteus.

Letter from Budapest Soliciting Money From Indianapolis Physician

The headquarters office was directed to take this matter up with the American Red Cross.

THE JOURNAL

(1) *Report on advertising:*

Additions	$978.66
Decreases	66.10
Total increase in June and July	$912.56
Total increase for year	$874.95

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

July 11, 1947.

Present: H. G. Hamer, M.D., chairman; David L. Smith, M.D., and Ray E. Smith, executive secretary.

The following news releases for daily and weekly newspapers were approved:

For release July 14, 1947 (A.M. papers)—"Swimming Called Safest Exercise for Hot Weather."

For release July 21, 1947 (P.M. papers)—"Hoosier Physicians Pick October Dates for Annual Meeting."

"Hints on Health" columns for weekly newspapers only were approved as follows:

Week of August 4, 1947—"Ragweed Hay Fever."

Week of August 11, 1947—"Poison Ivy."

Week of August 18, 1947—"Infantile Paralysis."

Letter from WFBM, stating that the state association radio program had to be changed from Monday afternoons to either 9:15 A.M. on Mondays or 10:30 P.M. on Fridays, was read. The Monday morning hour was selected. The secretary reported that the new series, "Fair and Cooler," would begin Monday morning, July 14, and conclude Monday, September 8.

The secretary made known that Mrs. Lyman Eaton, of Franklin, had been appointed chairman of the Woman's Auxiliary Radio Committee, and that she would like to write and produce a radio program, if it is the wish of the bureau. The secretary was instructed to invite Mrs. Eaton to the next bureau meeting so the subject could be discussed.

Report of a survey of state and county medical society radio programs by the Jackson County Medical Society, which embraces Kansas City, Missouri, was read. The secretary was directed to write for copies of radio program scripts used by the Jackson county society.

One of a series of advertisements being run by the Oklahoma State Medical Association was noted.

Suggested programs for county Woman's Auxiliary meetings for 1947-1948 were approved. The suggestions include the 1946-1947 topics, plus recruitment of student nurses, discussion of the Taft bill and other new medical bills before the 80th Congress, and sponsoring of health talks and social hygiene programs. The bureau decided that nurse recruitment should be the number one objective of the auxiliary.

BUREAU OF PUBLICITY

July 25, 1947

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The question of the Woman's Auxiliary to the Indiana State Medical Association sponsoring a radio program over one of the Indianapolis stations was discussed with Mrs. Lyman D. Eaton, of Franklin, chairman of the auxiliary's radio committee. The bureau voted to give the auxiliary radio time it now has on WFBM every fifth or sixth Monday, for the auxiliary to present a program of its own choosing. Script is first to be approved by the bureau before it goes on the air.

Request of the auxiliary's program committee chairman for suitable books which might be suggested for review at auxiliary meetings was taken under consideration.

A newspaper release, for afternoon papers on Monday, August 4, entitled, "Medical Association Offers Scholarships to Nursing Students," was approved.

The secretary was authorized to have an artist prepare a drawing for a new caption for "Hints on Health."

Wording of a suggested "Certificate of Distinction" for presentation to physicians who have been in practice for fifty years was approved.



Convenience is achieved and time saved through the use of National's "D-T-P" (Diphtheria-Tetanus-Pertussis Combined). These combined antigens are prepared from carefully standardized toxoids and bacterial vaccines which provide a maximum of activity in a minimum-dose volume. Alum precipitation, used in all combinations, produces more effective action in stimulating immunity response.

Diphtheria-Tetanus-Pertussis Combined is recommended for infants and pre-school children. Treatment consists of three subcutaneous injections at intervals of from three to four weeks.

Diphtheria
Tetanus
Pertussis COMBINED

ALUM PRECIPITATED

Diphtheria-Tetanus-Pertussis Combined is available in multiple-dose vials.

The NATIONAL DRUG COMPANY

THE NATIONAL DRUG CO. • Philadelphia 44, Pa.

PHARMACEUTICALS, BIOLOGICALS, BIOCHEMICALS FOR THE MEDICAL PROFESSION

LOCAL SOCIETY REPORTS

Fountain-Warren County Medical Society members met at Mudlavia on July seventeenth. Guest speakers were Dr. George Brother and Dr. Dan C. Barrett, of the Indiana State Board of Health. The general theme of the meeting was policies and methods of improving public health.

Owen-Monroe County Medical Society members held a meeting in Bloomington on July thirtieth. The guest speaker for this meeting was Dr. Dwain Walcher, of the Indiana University Medical Center who discussed the control and probable causes of poliomyelitis. Dr. Leroy Burney, commissioner of the Indiana State Board of Health, also addressed the group from the practical standpoint of the public concerning polio.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. A. W. Ratcliffe, Evansville.

President-elect—Mrs. William Morrison, Kokomo.

Corresponding Secretary—Mrs. J. W. MacDonald, Evansville.

Recording Secretary—Mrs. Truman Caylor, Bluffton.

Treasurer—Mrs. Wendell Kelly, Anderson.

Press and Publicity—Mrs. F. M. Gastineau, Indianapolis.

OUR GOAL

"Every Doctor's Wife an Auxiliary Member"

President's letter to Hoosier doctors' wives:

September—and with our rapidly expanding program, the correspondence involved, and the endless details to work out, I'm beginning to feel like the girl on that summer radio program who kept saying plaintively over the phone, "Don't fight it, Robert. It's bigger than both of us."

Speaking of radio brings us to a project we are working on. Mrs. Lyman Eaton, 291 E. Monroe St., Franklin, was appointed to our Press and Publicity Committee to see what could be done with furthering health education via radio. Some of you who attended Butler University and Jordan Conservatory in the thirties will remember her as Miss Alberta Speicher, who taught dramatics and who was with one of the Indianapolis radio stations for awhile. If you don't know her, I can tell you that she knows her way around in radio and has been busy rounding up information on a project every auxiliary should take advantage of. She has a list of radio stations in Indiana and is checking to see which of these use A.M.A. transcriptions. Also, she has a list of transcriptions and the cost involved. IF YOUR AUXILIARY IS OUT OF RANGE OF A STATION BROADCASTING AMERICAN MEDICAL ASSOCIATION TRANSCRIPTIONS, CONSIDER THE POSSIBILITIES OF USING THESE AS A HEALTH EDUCATION PROJECT. If Mrs. Eaton has not already contacted you with this information, write her at the above address to embark on a project which can be more far-reaching than any other.

Not content with just doing the above, Mrs. Eaton is planning live radio shows over WFBM occasionally. She has received permission from the Bureau of Publicity of the Indiana State Medical Association to use their time every fifth or sixth Monday (9:30 A.M.), to present a program for the auxiliary. The script will be approved by the Bureau of Publicity.

Did you receive your first "Hoosier Doctor's Wife?" They were mailed about the first of August. We ran into considerable difficulty with the post office, even after we had checked with them before doing the mimeography. Consequently, we had to put them in envelopes. The cost was considerably higher than our estimates. We learned a lot and next time we will no doubt run into a whole new set of difficulties. It's worth it, if you enjoyed it.

Mrs. Smith, our legislation chairman, is unable to get her outline ready for this issue of THE JOURNAL. This gives me a chance to discuss a subject which seemed to cause some consternation among those who attended the House of Delegates in April. At that time I urged auxiliary members to join organizations which take a stand for political medicine, rather than shunning them. Especially did I recommend that as many as possible become members of the League of Women Voters. There were several reasons for urging membership in the League, and at the time their stand on political medicine was *not* one of them. The real and urgent reason why you should become a member of the League is to become interested and learn the KNOW HOW of legislation and legislative procedure. Why? Because a year from next January, when the state legislature (General Assembly) convenes, we, the Indiana State Medical Association and the Woman's Auxiliary, are going to have a fight to the finish on the Chiropractic Bill. This year it was tough enough. Next time it's going to be worse. The chiropractic students and practitioners cut their teeth on this General Assembly and learned their way around. With a year and a half to reconnoiter and gather strength—I leave it to you. In the meantime, are you preparing yourself to be of help to the Legislative Committee when they call on you? Do you know your Senators and Representatives? Do they know you? It's gratifying to have a Senator or Representative tell you that he singled your letter out of the stacks of mail received and followed your advice because he knew you and respected your opinion. That is *our* job for the next year and a half—to reach the personal basis with every Senator and Representative. REMEMBER THE CHIROPRACTORS ARE NO DOUBT TRYING TO DO THE SAME THING.

You may ask me why I am dwelling on the state basis when we have federal legislation pending. If you have the KNOW HOW and the will to do your bit on the state basis, you will not hesitate to do the same thing on the national basis. We are much too inclined to start at the top and let the lesser things ride. That is the wrong end. As a matter of fact, even the state basis is too high. OUR DEMOCRATIC GOVERNMENT STARTS WITH *YOU*, AS A VOTER. Next on the rung of the ladder is your PRECINCT COMMITTEEMAN. Do you know your precinct committeeman? He's probably the most important man in our two-party system, and the least known. He's the name at the bottom of the ticket in the primary who often gets elected by 10 votes because you, the voter, had your sights too high and neglected to inquire about his qualifications. So then he's perfectly free to help elect the county chairman of your party who OK's every candidate for office in the party. Going up the ladder a little further, the county chairman helps elect the district chairman, etc., etc. See what I mean?

Well, I've been sitting at my typewriter all this time telling you the little I know about such things. Now, may I ask you a question? DOES ANYONE READ THESE LETTERS, BUT ME?

Rebecca Ratcliffe, President.

FALL GRADUATE INSTRUCTIONAL COURSE IN ALLERGY

Sponsored by

The American College of Allergists

Under the Auspices of

College of Medicine, University of Cincinnati

EDEN and BETHESDA AVENUES CINCINNATI, OHIO

Monday, November 3, 1947, Through Saturday, November 8, 1947

Objective: To provide a more comprehensive understanding of the many manifestations of allergy so commonly encountered by both the general practitioner and specialist and to emphasize methods of diagnosis and treatment of allergic diseases so that the physician is prepared to give the greatest aid to his patient.

Faculty: Forty-four specialists in allergy and related fields, from prominent medical centers and colleges. (For details see ANNALS OF ALLERGY, pages 249-252, May-June, 1947.)

Approach: *Basic concept* of chemistry, immunology, physiology, pathology, botany, pharmacology, and psychodynamics, as applied to the allergic patient.

Laboratory procedures, such as the preparation and standardization of extracts for testing and treatment, skin tests, serology, and other miscellaneous procedures, and their interpretation, together with history taking.

Treatment and management of the allergic patient, with special lectures and symposiums on the various allergic diseases.

Management of the problem case.

Teaching Methods: Lectures accompanied by lantern slides, movies, and other visual aids. Demonstrations of technical procedures and allergic patients. Discussions in which all can participate.

Communications: Make all inquiries, registrations for the Course, and reservations for hotel accommodations directly through the Secretary of The American College of Allergists, Dr. Fred W. Wittich, 423 La Salle Medical Building, Minneapolis, Minnesota. In asking for reservations, please state the exact time of your arrival and departure and if you want a single room or wish to share one with another registrant. The number of single rooms is limited. The fee for the Course is $100.

COMPLETE PROGRAM WILL BE MAILED ON REQUEST

Books

REVIEWED

FUNDAMENTALS OF CLINICAL NEUROLOGY. By Merritt, Mettler, and Putnam. Blakiston Co., Philadelphia, 1947. 289 pages.

The physician making a neurological examination will do well to follow this excellent guide. The illustrations are most helpful in making the anatomic diagnosis. It very clearly differentiates the many diseases involved as a result of the examination of the spinal fluid. While some parts are too technical for any but the expert, in general the book will serve well the average practitioner.

Charles N. Combs.

SYNOPSIS OF MEDICINE. Eighth edition. By Sir Henry Tidy. Williams and Wilkins Co., Baltimore, Md., 1947. 1215 pages.

This book is a marvel in the enormous amount of detailed information that has been crowded into it. For one who is about to undergo a factual examination nothing could be handier. It is not a textbook but a compendium for hasty reference and aside from the English style and nomenclature is entirely acceptable.

Charles N. Combs.

THE ANALYSIS AND INTERPRETATION OF SYMPTOMS. J. B. Lippincott Company, Philadelphia, 1944. 302 pages.

This volume, edited by Cyril M. MacBryde of St. Louis, has been reprinted from the Clinics of April 1944. Ten contributors have provided in these chapters an analytical method for the interpretation of some of the commonest symptoms which bring the patient to the physician. Nervousness and fatigue, fever, headache, thoracic pain, conditions which produce cough and hemoptysis, abdominal pain, hematemesis and melana, jaundice, joint pain, and obesity are discussed from the standpoint of differential diagnosis.

A quick reference to it will refresh one's mind as to the possibilities of a given diagnosis when presented with one of the above symptoms.

Charles N. Combs.

ONE HUNDRED YEARS OF GYNAECOLOGY. By James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital and of Columbus Hospital, New York; Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals; Consultant, Beekman and Downtown Hospitals. 651 pp. Cloth. Price $8.50. Published Sept. 5, 1945. The Blakiston Co., 1012 Walnut St., Philadelphia 5, Pa.

This book summarizes the progress of gynecology during its greatest century, 1800 to 1900. It gives information of all the literature dealing with diseases of women from every country. It classifies and arranges the material chronologically and makes it possible to clarify priority of contributions and discoveries. It is a book that should be in every medical library and will be a valuable companion to any physician who writes about gynecological subjects and who pays any attention to proper source and historical background.

Pierce MacKenzie.

UNHAPPY MARRIAGE AND DIVORCE. A Study of Neurotic Choice of Marriage Partners. By Edmund Bergler, M.D. Cloth. Price $2.50. Pp. 167. International Universities Press, 227 W. 13th St., New York, N. Y.

One wonders if the average physician is a great deal of help when patients, male and female, come to him for advice about marriage. The physician's lack of understanding and his own embarrassment often matches that of the patient.

Divorce is a serious social disease in the United States. Any attempt to understand its causes is worthy of study. This book is an attempt at explanation on the Freudian basis.

Sexual adjustment is imperative for a successful marriage. Tender or romantic love, as the author calls it, is a requirement for successful adjustment.

Neurotics who marry are a major cause of divorce. The author places much blame for adult neuroses on childhood problems and maladjustment.

It is the contention of Dr. Bergler that neuroses are curable.

There is much confusing and controversial material in this book but every practicing physician could gain much from reading it.

Pierce MacKenzie.

ESSENTIALS OF GYNECOLOGY. By Willard R. Cooke, M.D., F.A.C.S., Professor and Head of the Department of Obstetrics and Gynecology, University of Texas. Cloth. Price $6.50. Pp. 475. 197 Il. J. B. Lippincott Co., Philadelphia, London, Montreal.

"Essentials of Gynecology" is a practical book written by a practitioner of the art of medicine presenting his views of gynecology gained from association with women patients as a teacher and head of a university medical school. He is not presenting theories or untested procedures.

He stresses the importance of the patient herself. He states that "ninety per cent of the intensity of human suffering is mental" and that "many physiologic disturbances are psychic in origin."

That a considerable percentage of women patients are victims of too much leisure time, too little work, and too much food is pointed out; and he holds that rather than lead a more normal life, 90 per cent will not accept advice, and 80 per cent expect some operative procedure can cure them.

The pictures of gross and microscopic material are all of the author's own clinic. The other illustrations are original line drawings.

Througout the book medical and conservative treatment is stressed.

The author covers the field of gynecology in this book, including his method of history-taking and examination of the patient, anatomy, embryology, and endocrinology.

The final chapters are on the principles of operative treatment and the commonly used operations of gynecology. The operations are not illustrated but the discussions are designed to provide the practitioner with a working knowledge of surgical care with a step-by-step description of the essentials of the procedure.

The expert in gynecology, as well as the general practitioner, can gain from Dr. Cooke's practical opinions and his discussion of operative necessity.

Pierce MacKenzie.

Capillary hemorrhage, defying control by hemostat and ligature, speedily yields to THROMBIN TOPICAL. Seconds after local application, the operative field can be cleared of capillary bleeding.

THROMBIN TOPICAL affords prompt, on-the-spot clotting action. It is one of a long line of Parke-Davis preparations whose service to the profession created a dependable symbol of therapeutic significance—

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TOXEMIA OF PREGNANCY*

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and

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CINCINNATI

TOXEMIA of pregnancy is an acute vascular disorder which appears in the latter half of pregnancy. It is characterized by hypertension, albuminuria, and generalized edema. Soon after delivery the signs disappear, although permanent vascular and renal damage may persist in some cases.

CLASSIFICATION

The classification of toxemias of pregnancy has been the subject of much debate for years. The most generally accepted classification in this country has been the one suggested by the American Committee on Maternal Health, appointed in 1937, and subsequently modified in 1939.[1] In 1938 we started to classify our cases of hypertensive albuminuric pregnancy according to the system suggested by Dr. Kellogg[2] at the Boston Lying-in Hospital. This seemed the most logical and, with practically no changes, fitted into the comprehensive classification accepted by the above committee in 1939.

For simplification we have in this paper retained only four groups, namely: (1) hypertensive disease, (2) preeclampsia mild, (3) preeclampsia severe, and (4) eclampsia. Under *hypertensive disease* we have grouped all cases with underlying hypertensive, vascular, or renal disease, with or without superimposed toxemia. *Mild preeclampsia* has included all cases which showed a blood pressure of 140/90 or more, associated with albuminuria but without severe symptoms. *Severe preeclampsia* included cases with hypertension greater than 140/90, albuminuria and edema, usually of greater degree, and accompanied by symptoms such as headache, nausea, vomiting, vertigo, visual disturbances, et cetera. *Eclampsia* was reserved for severe cases in which convulsions actually occurred, in addition to the foregoing signs and symptoms.

PATHOLOGY

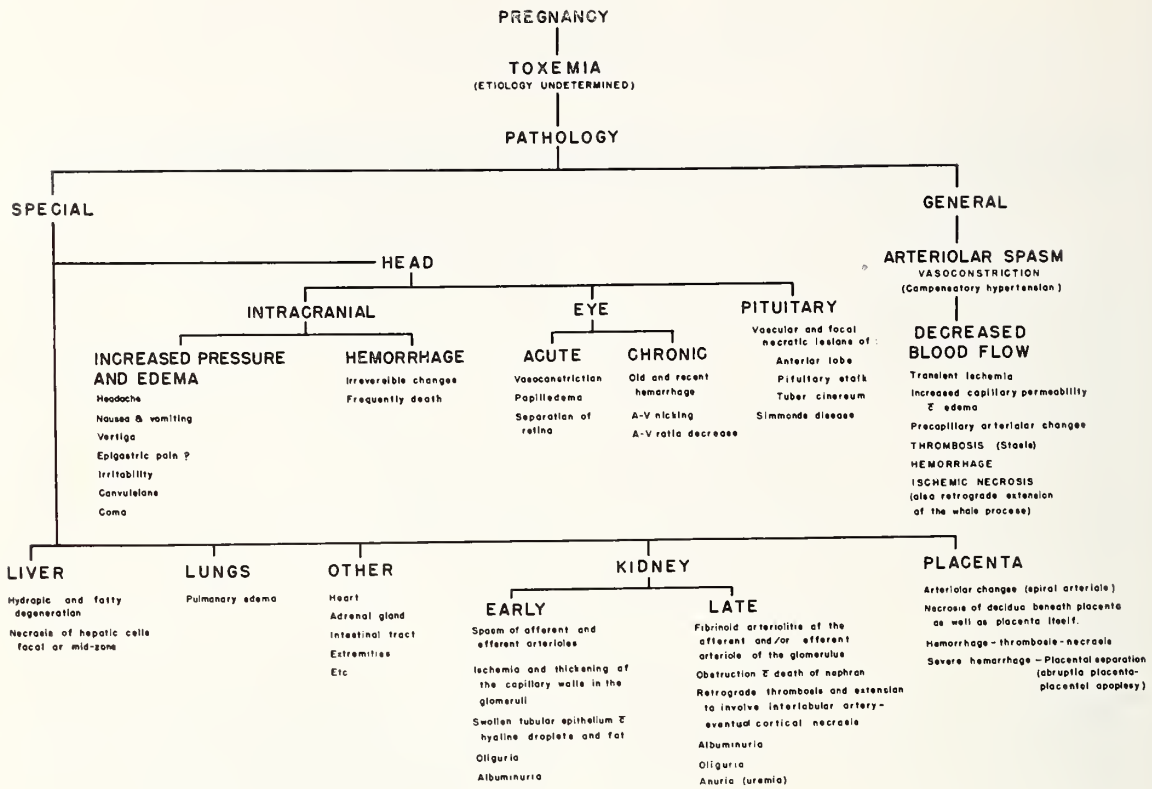
Plate I shows a schematic representation of the pathology encountered in toxemia of pregnancy. By definition, pregnancy is essential. Until the pregnancy is interrupted or until the fetus dies in utero the condition can be alleviated but not terminated. The etiology is obscure and will not here be further discussed. We do know that vasoconstriction does occur characteristically in toxemia of pregnancy with spasm or permanent changes involving the smaller arterioles. For several years I have taught empirically that, distal to the point of vasoconstriction, various changes are encountered in the following order: diminished blood flow, ischemia of the capillary wall with increased capillary permeability, edema and stasis followed by damage to the endothelium which resulted in thrombosis, hemorrhage, or both, and finally, tissue necrosis in the area involved. It is with extreme pleasure that now I can quote with assurance from an authority on obstetrical pathology the actual vascular findings encountered at autopsy on patients who died of eclampsia or following toxic

* Presented before the General Meeting of the Indiana State Medical Association at the annual meeting in Indianapolis, October 30, 1946.

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1. Mussey, R. D., et al.: The Mother, *Quarterly Bull. Am. Com. on Maternal Health, Inc.*, Chicago, April, 1940.
2. Kellogg, F. S., et al.: Recent Experiences with a New Classification of Pregnancy Complicated by Hypertension and Albuminuria, *Am. J. Ob. & Gyn.*, 33:300, 1937.

PLATE I



separation of the placenta. I quote from Hertig,[3] "All lesions, regardless of age or location, appeared to form in a similar manner. There was degeneration of the arteriolar wall near or at the point of division of the arteriole into capillaries. In most instances the degeneration led to gradual obstruction of the vessel lumen by thrombi. Hemorrhage into the arteriolar wall and surrounding tissue followed, with resulting ischemic necrosis. Thrombosis, however, did not appear to be a necessary factor, since ischemic necrosis of the tissues sometimes directly followed the lesion of the arteriolar wall. Retrograde extension of the degeneration in the arteriolar wall with or without accompanying thrombosis occurred in most instances. With the involvement of more and more arterioles and subsequent retrograde extension, ischemic necrosis involved continually larger areas. The extent of this necrosis varied with the presence of collateral circulation in the different organs."

With this general picture in mind, we may now consider this process as it occurs in the various special areas or organs of the body. In the head, or intracranially, with the occurrence of increased pressure and vasospasm there develop the classical signs of increased intracranial pressure, namely: headache, vomiting, and choked disk. The other signs and symptoms follow in rapid succession. They are vertigo, possibly epigastric pain, increased irritability, twitching, convulsions, and finally coma. If hemorrhage occurs, which is not infrequent, the neurological signs vary with the site and extent of the lesion and are more or less permanent. Death may result.

In severe preeclampsia one may observe vasoconstriction in the small arterioles of the optic fundus. Occasionally papilledema is noted if the intracranial pressure is increased, appearing first on the nasal side of the disk. On several occasions I have also seen detachment of the retina due to edema of the choroid or vascular layer beneath the retina. In toxemia of pregnancy this complication bears a good prognosis since it is due to edema and not to extreme myopia, which is the usual cause for such accidents. I have observed one patient in whom the vision returned spontaneously to normal of 20/20.

When a patient is seen for the first time late in pregnancy, observation of the eyegrounds affords the best method of differentiating between hypertensive disease of long standing and severe preeclampsia. If hypertensive disease has been present for some time the arterioles are constricted, tortuous, and of the "silver wire" type. Arteriovenous nicking is present and the usual arteriovenous ratio of ⅔ is diminished, for example, to ¼. Further-

3. Lull, C. B., *Management in Obstetric Complications*, J. B. Lippincott Co., Philadelphia, 1945. Chapter on "Toxemias of Pregnancy" by Kellogg, F. S. and Hertig, A. T.

more, evidence of recent as well as of old hemorrhage may exist, possibly with exudate.

Within the pituitary gland vascular and focal necrotic changes have been observed in the anterior lobe, stalk, and tuber cinereum. Hertig[3] maintains that Simmonds Disease is part of the general pathologic picture of toxemia and may be a factor subsequently in producing the "hemophiliac tendency" of the blood in toxic separation of the placenta and other toxemias. Simmonds Disease, or cachexia hypophysea, according to Stedman,[4] is a triad of symptoms—premature ageing, rapid atrophy of the genital organs with repression of the secondary sexual characters, and loss of hair—noted usually in comparatively young women due to atrophy or diminished function of the hypophysis cerebri.

In the liver capillary dilatation, hemorrhage, thrombosis, stasis, together with hydropic and fatty degeneration may be observed, with depletion of the glycogen store. In severe preeclampsia and eclampsia necrosis of hepatic cells is found, usually at the periphery of the lobule, but it may be focal or mid-zonal. When sufficient damage has occurred to cause jaundice, the prognosis is poor.

In the lungs edema is frequently found. In eclampsia pulmonary edema may be fatal.

Pathologic changes in the kidneys are of great importance. Early manifestations are spasm of the afferent and efferent arterioles with ischemia and thickening of the capillary walls within the glomeruli, also swelling of the tubular epithelium with hyaline droplet and fat deposit. Albuminuria and oliguria result. In fatal cases Hertig[3] has observed a "fibrinoid arteriolitis" of the afferent and efferent arterioles in the juxtaglomerular area. Where obstruction is complete the nephron dies. Retrograde thrombosis and extension of the necrosis may involve a whole area of the cortex, particularly when the interlobular arteries become involved, with damage to the whole area supplied by them. Oliguria may be followed by anuria and death. This is especially true following severe toxic separation of the placenta.

According to Weiss[5] the placental changes consist chiefly of premature ageing and syncytial degeneration. Here again the fundamental or general process outlined above may be observed. Changes occur in the small spiral arterioles which supply the placenta with blood and nourish the underlying decidua. As thrombosis, stasis, hemorrhage, and necrosis occur in various stages and degrees it is possible to find, even grossly, in toxic placentas, hemorrhagic areas, both fresh (red infarcts, so-called), and old (white infarcts) or scarred areas. When retroplacental hemorrhage is of severe degree and uncontrolled the placenta becomes detached. The bleeding may be completely concealed or visible. If more than one third of the placental area becomes involved in either process, necrosis and degeneration or separation from hemorrhage, the infant usually dies in utero. When separation is acute the life of the mother is greatly endangered.

4. *Stedman's Practical Medical Dictionary,* The Williams & Wilkins Co., Baltimore, 1942.
5. Weiss, S. and Dexter, L.: Hypertensive Toxemia of Pregnancy—Pre-eclampsia and Eclampsia, *J.A.M.A.,* 122:145, 1943.

Treatment

Treatment consists of three stages: (1) prophylactic, which attempts to prevent toxemia of pregnancy; (2) therapeutic, which attempts to alleviate the process; and, finally (3) termination of the pregnancy to prevent permanent damage to the mother and to save the infant, if possible.

Prophylactic. Prophylactic measures consist of maintaining good prenatal care and hygiene, together with avoiding excessive weight gain. Rest is essential. Adequate fluid intake is necessary and, to prevent edema, sodium in the form of salt and soda must be restricted in the latter half of pregnancy. Potassium or ammonium chloride may be substituted.

Therapeutic. When preeclampsia develops, in spite of prophylactic precautions, therapeutic measures must be established to alleviate the condition until it can be terminated by interruption of the pregnancy. A brief outline of therapy follows:

1. Absolute bed rest in the hospital.
2. Maintain fluid balance and promote absorption of edema and diuresis:
 a. Force fluids from 3,000 to 5,000 cc. daily.
 b. No NaCl.
 In this connection it is interesting to note that Paul White[6] has recently had reasonable success in treating patients with congestive heart failure by this method. He stresses the importance of restricting the sodium chloride intake to 2 Gm. or less per day. To do this, ordinary bread must not be eaten. He states, "The heart is able to support the increase of fluid intake, despite former fears, and the kidneys are able to work much more effectively."
 In severe cases for years we have not been satisfied with a "Salt free diet" but have given only milk (maintenance protein), fruit juices, and carbohydrates (baked potato and cereal, both salt free).
 c. Adequate protein intake—for replacement and to maintain normal osmotic pressure.
 d. Hypertonic glucose—to promote absorption of edema, to secure diuresis and to replace glycogen badly needed by an already damaged liver.
 e. Magnesium sulfate—to promote absorption of edema, and by mouth to act as a saline cathartic. As will be noted later it also acts as a depressant to the central nervous system.

6. White, Paul D., et al.: Low-Sodium Diet and Free Fluid Intake in the Treatment of Congestive Heart Failure, *N.E.J.M.,* 234:573, 1946.

3. Decrease the irritability of the central nervous system.
 a. Magnesium sulfate.
 b. Sedatives. Morphine and chloral hydrate (Stroganoff): more recently barbiturate derivatives and paraldehyde have been the chief drugs employed in most clinics to allay the convulsions of eclampsia. Their use is far down the scale in point of action since they act only to decrease the irritability of the central nervous system. We have not employed sedatives because morphine inhibits the action of veratrone and because we feel that the true clinical picture is masked by other sedatives. With veratrone and magnesium sulfate, narcotics and sedatives are unnecessary.
4. Secure vasodilatation with Veratrum viride in order to reverse the vicious process initiated by abnormal vasoconstriction. In a very comprehensive review of the pharmacology of the Veratrum alkaloids, Krayer and Acheson[7] note that the many alkaloids of Veratrum vary somewhat in their action and need further study. Excerpts from their article are quoted here in places. They point out that the action on the circulatory system is (1) depressor, (2) cardio-decelerator, and (3) in large dosage, pressor and cardio-accelerator. The depressor or vasodilatation action is independent of the cardio-deceleration action. Experiments demonstrate that a diminution of arterial resistance is involved in the blood pressure decrease caused by veratridine. Similarly increases in the capacity of the vascular bed have been observed in the liver, intestine, and kidney of experimental animals. Retinal arterioles have been observed to dilate during the blood pressure fall. Direct quantitative measurements of blood flow in the femoral arteries of anesthetized dogs show a marked absolute increase in blood flow during the blood pressure decrease caused by the intravenous injection of veratridine or proto-veratrine.

 The mechanism mainly operative in the vasodepressor response to small doses of Veratrum alkaloids is a vasodilatation of reflex nature. Most of the afferent pathways of the reflex run in the vagus nerves, none apparently in the aortic nerves, and in the sympathetic outflow of the autonomic (parasympathetic) nervous system. Other areas not served by the vagus (including the glomus caroticum) contribute to the effect.

 Cardio-decelerator action of the Veratrum alkaloids in the mammal is caused in part by reflex and in part by central vagal stimulation.

 Clinically we have found the proprietary preparation "veratrone" to be a strong parasympathomimetic drug, the action of which is nearly the exact opposite of adrenalin. It promotes vasodilatation, increases the blood flow, and thereby reverses, in so far as possible, the vicious process outlined under general pathology above. Other effects are lowering of the blood pressure, slowing of the heart rate, vomiting, increased peristalsis (sometimes diarrhea), and increased sweating, or hidrosis. The latter two promote excretion. Some fear[8] that renal function is dangerously decreased by this drug. We have not encountered any deaths attributable to it. Renal and cardiac failure have not resulted from its use.

 Morphine should not be used if results from Veratrum viride are expected. Clinically it may be employed as an antidote for overdosage from veratrone, although we have not found this necessary. Magnesium sulfate seems to enhance the results from veratrone.

 It is gratifying to quote from Kellogg,[3] "We have found it (veratrone) the fastest way to control convulsions in eclampsia and to lower blood pressure in severe preeclamptics on the verge of convulsions. Thus we can treat an eclamptic as a preeclamptic and improve the severe preeclamptic and so empty the uterus more safely. It does not save moribund patients for us."

Termination of Pregnancy. Toxemia of pregnancy is not arrested completely until the pregnancy is terminated. Occasionally following death of the fetus in utero the signs disappear. Following the appearance of preeclampsia or eclampsia one must constantly anticipate interruption of the pregnancy at the most opportune time. If possible, a living infant must be salvaged but not at the expense of permanent vascular damage to the mother. The danger of persistent hypertension in the mother increases not so much with the severity of signs but more with the duration of the condition. Since placental degeneration also increases with the duration of toxemia, danger to the child increases likewise. At best the child is often undersized for the gestational age. With this in mind, according to Kellog,[9] "We may accept with Irving, Dienna, Waters and others that the 35 week preeclamptic baby has its best chance out of the uterus providing the method of emptying the uterus is not fatal to it."

Pregnancy may be terminated from below provided the cervix is amenable to induction of labor. We have most frequently resorted to "stripping of the membranes," followed by castor oil by mouth

7. Krayer, O., and Acheson, G. H.: The Pharmacology of the Veratrum Alkaloids, *Physiol. Reviews*, 26:383, 1946.
8. Willson, J. R.: Veratrum Viride in the Treatment of the Toxemias of Pregnancy, *Am. J. Ob. & Gyn.*, 52:273, 1946.
9. Kellogg & Irving—see reference 3.

Table I

TOTAL NUMBER OF CASES - 1310				
YEAR	MILD	SEVERE	ECLAMP.	HYPERT. DISEASE
1940	154	40	8	48
1941	133	68	7	31
1942	163	119	10	33
1943	93	71	4	29
1944	75	58	3	36
1945	62	23	8	34
TOTAL	680	379	40	211

Table 2

FETAL MORTALITY								
GRADE OF TOXEMIA	TOTAL NO OF CASES	STILLBORN		NEO-NATAL DEATHS		TOTAL INFANT DEATHS		ABOR.
		PREM.	TERM	PREM	TERM	TOTAL	%	
MILD	680	9	13	10	5	37	5.5 %	0
SEVERE	379	16	19	8	6	49	12.7 %	0
ECLAMPSIA	40	4	2	2	3	11	27.5 %	0
HYPERTENSIVE DISEASE	211	12	12	4	5	33	15.7 %	15
TOTAL	1310	41	46	24	19	130	9.8 %	15

and enema. This may be repeated. This failing, we have frequently used the Gillespie Bag, feeling that there is far less danger to the infant with it than following artificial rupture of the membranes. When the latter method is employed the small, premature head bears the entire brunt of the labor. Infection and prolapsed cord may be encountered following use of a bag.

Cesarean section is used only when the cervix is not prepared for induction of labor or when some other indication for Cesarean section exists.

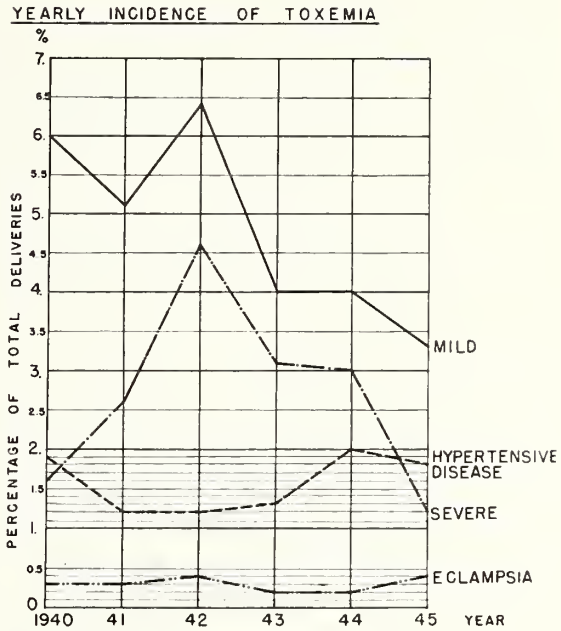
Where hypertensive disease pre-exists, Weiss[5] claims that only 50 per cent of the patients develop superimposed preeclampsia. The fetal loss is necessarily high in such cases. Thus, prevention of pregnancy by education and its interruption by therapeutic abortion or hysterotomy, followed by sterilization, is often wise.

INCIDENCE

During the six years 1940 through 1945, inclusive, there were 13,784 deliveries at the Cincinnati General Hospital. Of these, 1,310 or 10 per cent showed some form of hypertensive albuminuric disease. Table I shows the annual figures according to the type of toxemia. There were 680 cases who had mild preeclampsia, 379 had severe preeclampsia, 40 had eclampsia, and 211 had hypertensive disease, as previously defined. The number of mild cases seems low because a large number of patients were excluded since they did not have hypertension or albuminuria for at least two consecutive readings.

Plate II shows the annual incidence of each type of toxemia relative to the total number of deliveries. Since 1942 mild and severe preeclampsia show a steady decrease. This is due in part to improved

PLATE II



prenatal care. The occurrence of hypertensive disease and eclampsia has changed only slightly.

FETAL MORTALITY

In the past six years 130 fetal deaths (stillbirths and neonatal deaths) occurred in the series of 1,310 toxic cases, a gross mortality rate of 9.8, or nearly 10 per cent. As table II shows, the infant loss was 5.5 per cent in mild preeclampsia, 12.7 per cent in severe preeclampsia, 27.5 per cent in eclampsia, and 15 per cent in hypertensive disease. In the hypertensive group there were 15 cases of abortion, either spontaneous or therapeutic, before 4½ months gestation, bringing the over-all fetal loss in hypertensive disease to 22.7 per cent.

Of the 130 infant deaths, 87 were stillborn and 43 died neonatally. The total of infant deaths was equally distributed between premature and term fetuses. This unusual finding may result from our classification of gestation by duration of pregnancy rather than by weight of the infant at birth. Actually one should take into account duration of pregnancy, weight of the infant at birth, body length, and the ratio between the circumference of the head and shoulders. Our fetal mortality agrees practically with that found in other clinics.

TOXIC SEPARATION OF THE PLACENTA

There were 17 cases of severe toxic separation of the placenta with one maternal death from hemorrhage, a maternal death rate of 5.9 per cent. Two infants survived. Treatment was as follows:

Outside delivery	1 case
Artificial rupture of membranes alone	6 cases
Artificial rupture of membranes & bag	9 cases
Braxton Hicks' version	1 case

Hysterectomy in one case was done for uncontrolled postpartum hemorrhage. She survived. No Cesarean sections were done in this particular group of cases although we feel that this is the method of choice where the cervix is uneffaced and firm, particularly in primipara where a long labor is anticipated and where operation is not contraindicated by the condition of the patient.

CESAREAN SECTION

There were ten Cesarean sections in the entire series, an incidence of 0.7 per cent. They were distributed as follows:

Hypertensive disease	1
Preeclampsia mild	5
Preeclampsia severe	3
Eclampsia	1

The indications were as follows:

Disproportion	8
Cervical dystocia	1
Complete central placenta praevia	1

Nine children survived, one died a neonatal death (complete placenta praevia). There were no maternal deaths. Eight of the sections were of the low cervical type, two were of the classical variety.

In addition, four therapeutic abortions in the hypertensive group were done by abdominal hysterotomy followed by sterilization.

Maternal Mortality. There were four maternal deaths, a gross maternal mortality rate of 0.3 per cent. Death was assigned to sepsis in one case, to hemorrhage in two cases, and to eclampsia in one case. These were distributed as follows:

	Deaths	Cases	Maternal Mortality
Hypertensive disease	0	211	0.0 %
Mild preeclampsia	1	680	0.15%
Severe preeclampsia	2	379	0.53%
Eclampsia	1	40	2.4 %

Case 1. 1941. Unit No. 162502. Colored, 42 years, Para VI. Marked obesity, admitted in active labor with mild preeclampsia. B.P. 150/98, albumen ++, no symptoms. Labor twenty-six hours duration, no fetal heart audible for two hours before delivery. Difficult breech extraction under ether anesthesia produced a stillborn colored male infant which weighed 11 pounds, 6 ounces. A second degree laceration was closed with interrupted sutures. The estimated blood loss at the time of delivery was 1,000 cc. Following delivery the temperature rose to 106 degrees. With sulfanilamide and transfusions she improved during the first week. From the eighth to the twelfth day her temperature did not exceed 101 degrees. On the thirteenth day she became worse and died of sepsis fourteen days after delivery.

Comment. Mild preeclampsia in all probability did not contribute to the death of the patient. Penicillin might have saved her life had it been available.

Case 2. 1941. Unit No. 126569. Colored, 33 years, Para. VI, P. 90, B.P. 250/150, admitted with classical signs of severe preeclampsia and complete toxic separation of the placenta or abruptio placenta with concealed hemorrhage. She was given veratrone and Mag. Sulf. Sterile vaginal examination revealed dilatation of two fingers, the membranes were artificially ruptured, and she delivered spontaneously three and one-half hours after admission. The stillborn colored female fetus weighed 4 pounds, 9 ounces. Delivery was immediately followed by the already detached placenta and much retroplacental blood clots. Two hours after delivery the uterus was packed because of postpartum bleeding. One thousand cc. of blood were given together with oxytocic drugs. In spite of packing, the hemorrhage persisted and the patient died six hours and fifteen minutes following delivery, of peripheral circulatory collapse, resulting from uncontrolled hemorrhage.

Comment. Packing immediately after delivery, together with more blood, and possible hysterectomy might have saved the life of this patient. A similar case following so-called conservative treatment of complete toxic separation of the placenta, less than one month after this case, likewise had uncontrolled postpartum hemorrhage, in spite of packing. Following hysterectomy she recovered.

Case 3. 1944. Unit No. 126569. Colored, 30 years, Para VI. No prenatal care. Preeclampsia severe. P. 116, B.P. 210/130 (on previous admission, in 1942, B.P. 128/76). At that time she delivered spontaneously, after a three-hour labor, a normal living infant which weighed 10 pounds, 11½ ounces. At the time of this admission she had been in labor one hour, the membranes had ruptured one-half hour after the onset. Frank breech with nearly complete dilatation was confirmed by sterile vaginal examination one hour after admission. Following complete dilatation for several hours without progress, seven and one-half hours after the onset of labor a breech extraction was done with great difficulty. The stillborn infant weighed 14 pounds, 12 ounces. During delivery the placenta was partially separated. Delivery was accompanied by blood loss of about 750 cc. The patient died on the table, the cause of death primarily shock with contributing factors of severe preeclampsia, trauma of delivery, intra- and postpartum hemorrhage, together with anesthesia of about one and one-half hours duration.

Comment. X-rays and Cesarean section might have saved the life of this patient.

Case 4. 1944. Unit No. 195856. White, 22 years, Gravida I. Six months pregnant, no prenatal care. History of edema for several weeks, dismissed from Receiving Ward twenty-four hours before, when she entered, complaining of severe headache and epigastric pain, with vomiting.

She entered having had several convulsions, TPR 106, 120, 28; B.P. 200/80, B.U.N. 12 mg.%, CO_2 29 vol. %. She had two convulsions after veratrone and Mag. Sulf. were given. In spite of oxygen and hypertonic glucose the coma became worse, accompanied by cyanosis and terminal pulmonary edema. She died five hours after admission, undelivered. The final diagnosis, death from eclampsia, probably with cerebral hemorrhage. Autopsy unfortunately was not permitted.

Comment. Had the receiving physician admitted this patient twenty-four hours sooner she probably would have survived. This was gross neglect. *Hers is the only death we have had from eclampsia per se in 16 years.*

Comparative Statistics. In Table 3 a few comparative statistics are recorded. It is difficult to compare figures because some writers record all cases of preeclampsia, whereas others record only the severe cases.

Under eclampsia we note all eclamptics who died. Stander[10] and Davis[11] include only cases which died of eclampsia. There is considerable difference.

The best figures are those of Arnell[12] with no deaths in 142 consecutive eclamptics. For the 16 year period 1930-1945 at the Cincinnati General Hospital the authors cases were superimposed upon those of Bryant and Fleming.[13] In the entire series of 160 consecutive cases of eclampsia there were three deaths, two from sepsis, recorded by Bryant and Fleming, one from eclampsia per se by the authors. The maternal mortality for the entire series of eclamptics was 1.8 per cent and from eclampsia per se 0.6 per cent. It is gratifying to note that the incidence of eclampsia has been considerably reduced in the past six years. There has been little change in the fetal mortality from eclampsia.

10. Stander, H. J.: *Textbook of Obstetrics*, D. Appleton-Century Co., New York, 1945.
11. Davis, M. E. and Gready, T. G.: A Review of the Maternal Mortality at The Chicago Lying-in Hospital, 1931-1945, *Am. J. Ob. & Gyn.*, 51:492, 1946.
12. Arnell, R. E.: A Therapeutic Regimen for Eclampsia, *Am. J. Ob. & Gyn.*, 49:49, 1945.
13. Bryant, R. D. and Fleming, J. G.: Veratrum Viride in the Treatment of Eclampsia: II *J.A.M.A.*, 115: 1333, 1940.

TABLE III

	COMPARATIVE STATISTICS							
	PRE-ECLAMPSIA				ECLAMPSIA			
	Cases	Deaths	Maternal Deaths	Infant Deaths	Cases	Deaths	Maternal Deaths	Infant Deaths
Kellagg & Irving 1940-1944	Severe 114	1	0.8 %		22	3	13.5%	60. %
Oleckman & Davis 1940-1945	All 3,435	2	0.018%		86	4	4.6%	26 %
Stander 1933-1944	Severe 368	0	0.0 %	12.2%	70	1	1.4%	20 %
Arnell 1939-1943					142	0	0.	24.2%
Eastman 1924-1943	All 2,326	4	0.2 %	6.8%	92	7	7.6%	21.7%
Huber 1938-1943					51	12	23.5%	35 %
Cinti Gen Hosp 1940-1945	Severe 379	3	0.8 %	11.8%	40	1	2.4%	27.5%
Cinti Gen. Hosp. 1930-1945					160	3	1.8%	29.4%

DISCUSSION

The pathology of toxemias of pregnancy has been outlined and the objectives of treatment stressed. Under therapy we have emphasized bed rest, low sodium intake, the use of magnesium sulfate intramuscularly and by mouth, and hypertonic glucose. So far we agree with the treatment employed by most clinics in this country.

We differ, however, in that we advocate forcing of fluids, despite edema, with excellent results. We have not resorted to the usual sedatives and narcotics to decrease irritability of the central nervous system. Finally, we have persistently used Veratrum viride as a most successful adjunct in the treatment of hypertensive albuminuric pregnancy. Although used empirically for years the rationale is at last beginning to be appreciated.

SUMMARY

1. The classification, pathology, and treatment of the toxemias of pregnancy were outlined.
2. A six-year statistical study of 1,310 cases of toxemia of pregnancy at the Cincinnati General Hospital was presented. The over-all incidence of hypertensive albuminuric pregnancy was 10 per cent.
3. The gross fetal mortality was 9.8 per cent.
4. There were ten Cesarean Sections, an incidence of 0.8 per cent, with no deaths.
5. Severe toxic separation of the placenta occurred in seventeen cases. There was one maternal death, or a maternal mortality rate for this complication of 5.9 per cent.
6. There were four maternal deaths, a gross maternal mortality rate of 0.3 per cent.

ALL SESSIONS AT THE ANNUAL MEETING WILL BEGIN AT THE EXACT TIME THEY ARE SCHEDULED. PLEASE BE PROMPT IN ATTENDING THEM, IN ORDER TO MISS NONE OF THE EXCELLENT PROGRAMS.

RECENT SURGICAL ADVANCES IN THE TREATMENT OF ULCERS OF THE DUODENUM*

KARL A. MEYER, M.D.†

CHICAGO

THE treatment of duodenal ulcer is rather intriguing, and offers at times problems that tax the ingenuity of the surgeon, both from the standpoint of diagnosis and from that of technical procedure. Surgery of duodenal ulcer is, as a rule, synonymous with surgery of the complications of ulcer, with certain exceptions. In general, the treatment of duodenal ulcer is definitely medical. The factors that produce ulcer are many, but gastric hypermotility and hyperacidity are among the most prominent. The ideal treatment, medically, of the ulcer problem is therefore the control of the acid factor, and also the control of the hypermotility that is present. If we can control these two factors, we can control the intractability of these ulcers in most instances.

The basis of the above medical control was furnished by the work of Sippy, of Chicago. I have had the good fortune to have been on his service for a period of six months. Why I turned to the arduous task of being a surgeon, as compared to the comparative complacency of the medical man, with no worries, no trials, no tribulations, I don't know. But certainly Sippy's teachings and his intense interest in the ulcer problem have made everyone conscious of this very interesting problem and of the rewards that are reaped by the medical men by adequate medical care. The difference, of course, between Sippy's work and that of gastro-enterologists of the younger generation was that he cared for the patient over a twenty-four hour period. It was not a thorough medical management for twelve hours a day, but for twenty-four hours a day. Consequently, those of us who have followed his work realized that he practically taught each individual patient the use of the Ewald tube. His patients were experts in aspirating their own stomachs; they were experts in the dietary regime necesary to correct their symptoms. The fact that he worked on the patient for a twenty-four hour period gave him a very high percentage of medical cures in comparison to those reported by some of the surgeons of the same period.

I know that some men of the older group would question the medical management and would state that all cases should be operated on. Sippy always came back with a rebuttal, but could not hold his own in the battle that was going on at that time. I don't believe any of the surgeons today would refute Sippy's teachings. Certainly, the ideas of multiple feedings, with ensuing control of the acid factor, of rest, aspiration, and attention to the psychosomatic factor—the latter is not new, although you would at times be made to think we had discovered a new branch of medicine today—all of these were carried out in an adequate Sippy management.

Sippy's medical management consisted of control of the acid factor, of the hypermotility, and of good emptying. It is therefore the duty of the surgeon to look after the same physiological principle in the surgical treatment of ulcer. As I stated above, the ulcer problem is a medical one; the surgeon should be called upon only when complications are present.

Surgical complications of peptic ulcer are perforations, massive hemorrhage in certain ages, high grade pyloric obstruction, intractability, and fistula formation. Occasionally, surgery is indicated in cases of abscess formation that follow formes frustes perforations, described by Singer and Vaughn of the County Hospital. I believe that the newer concept of ulcer surgery consists of radical procedures for the eradication of the lesion. No one will debate the fact that every perforated ulcer should be operated upon. No one will debate the question that in a definite pyloric obstruction, with absolute cicatricial contraction of the duodenum, surgery should be instituted. In these latter cases, particularly in the older individual with a low acidity, the probabilities that a gastro-enterostomy will pay dividends and give excellent results are very good. There are, however, cases of ulcer in the aged in whom ulcer symptoms recur if a gastro-enterostomy is done, so that in a certain number of patients with pyloric obstruction, with a high acidity, as shown by tests with histamine, or caffeine, or whatever method of stimulation one uses, subtotal resection should be the operation of choice. We believe in very radical resections when operating on patients with duodenal ulcer; in other words, we do not believe in gastro-enterostomy, an indirect operative procedure for twenty-five years. There is too high a percentage of gastro-jejunal ulcers following this type of operation. The newer concepts of surgery for peptic ulcer, as brought out by the work of Dragstedt and his group at the University of Chicago, concern the effects following bilateral section of the vagus. It might well be that many more patients who have partial obstruction with marked hypersecretion and marked hyperacidity, will have a section of the vagus below the diaphragm rather than a high gastric resection.

The patient with intractable ulcer, in our observation, has other complications, also. In other words, a patient doesn't have an intractable ulcer

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unless he has an ulcer that has broken through into the surrounding organs or some degree of obstruction is also present. Very frequently the patient with intractable ulcer has penetration into the pancreas, frequently obstruction, and frequently bleeding.

The teaching of Clarmont, that every perforation cured itself, is also a fallacy. In a recent study covering 275 cases of perforation it was shown that 60 per cent demanded surgical intervention at a later date. Patients whose ulcers perforate bleed in much greater proportion, they become intractable in a much higher percentage, and they also reperforate in a much higher percentage than do the ordinary duodenal ulcers.

Intractable ulcer, if it is to be cured by surgery, has two avenues of approach at the present time. One is the high gastric resection, in which we have to remove practically 70 to 75 per cent of the stomach if we are going to have adequate postoperative results. In other words, if we do a simple pylorectomy of Rodman, and do not take out the greater part of the acid-producing fundus, we are going to have a recurrence in 25 to 30 per cent of the cases. This can be detected at the end of two weeks. If one uses histamine in testing the acid factor, he does not have to wait for a period of years to elapse before he finds out about a recurrence; he can detect it immediately. If the patient has a high acid content the surgeon will know that the clinical results will be poor. To obtain excellent results we must remove all of the pyloric antrum and the greater part of the acid glands of the fundus. Such a patient will be grateful for having undergone this surgery by your hand.

There are technical details that are sometimes insurmountable when you deal with a patient with marked edema and inflammation about the duodenum. In other words, the removal of all of the pylorus is sometimes a surgical impossibility and it might be a very dangerous affair. Seventy-five per cent of the complications that occur after resection are due to a blowout of the duodenal stump, and only 25 per cent are due to general complications or to malfunctioning. If you find a marked inflammatory reaction about the pylorus, then certainly a two-stage operation would be the operation of choice, as shown by McKittrick and his group. Do the resection, leave the pyloric antrum —about two inches of it—and close after the method of Finsterer. Do the resection first and then go back and remove the pyloric antrum, remembering that all patients will improve with the first stage of surgery, but many will have recurring ulcers. If you expect to have permanent results, the patient should have the second stage operation, even if he feels fine and doesn't want to return for the second operation. He must be told about the two-stage resections so that he will understand the importance of the second resection. Evidence for this is that very frequently in operating on a patient with a recurrence we have found the pyloric antrum present, the removal of which stopped recurrence of ulcerations, and led to a perfect operative recovery.

So much for the question of high resections. It is an operation which gives approximately 90 per cent excellent results if properly done; i.e., removal of the pyloric antrum and most of the fundus in all cases, at the primary or second operation.

The question now in most of our minds is how to evaluate the newer conceptions of surgical treatment, namely, the work of Dragstedt at Chicago. Is it going to be a simple procedure to section both vagi nerves and what will be the results in these cases? In my private practice I have done only one case of section of the vagus, although in my clinic at the County Hospital I have sectioned the vagi on twenty-five patients. In this group only patients with recurrent ulcers after high resections were done. Some of these patients have had the most severe types of pain and have been immediately relieved of all of their distress after a vagotomy. The final results of vagotomy will have to be appraised much later. The patients who have obstruction of the stomach will have to have supplemental surgery in addition to vagotomy. In other words, one would have to do a gastro-enterostomy and section the vagi intra-abdominally, which is more difficult.

Clinically, what is the effect of vagi section on gastric secretion and on gastric motility? It is this. The average normal individual, when tested from 8:00 o'clock at night to 8:00 o'clock in the morning will have a secretion of about 300 cc. of gastric juice of normal free acidity and normal combined acidity. The individual with duodenal ulcer will have a high night secretion, two to three times the normal secretion. That is also the reason why Sippy taught his men and his patients to use the Ewald tube; in other words, they aspirated themselves and never allowed the secretion to accumulate. With a hypersecretion there is hypermotility, hyperacidity, and night distress. Consequently, reduction of hypersecretion reduces the other factors also. In other words, if a man has a thousand cc. of high acid retention at night, and a vagi section is done, his secretion will go down to 200 or 300 cc. of normal acid gastric juice, and undoubtedly that plays the greatest factor in the ulcer problem. This again bears out the teaching of Sippy, that it is the acid factor that is the important factor in the treatment of ulcer. Vagotomy also stops hypermotility and one will observe a much slower emptying of the stomach by x-ray. Patients will have a 10, 15, 20, or sometimes 100 per cent retention at the end of four or five hours, so that it is imperative that when a section of the vagi be done, either through the chest, transthoracically, or below the diaphragm, continuous aspiration for a period of four or five days be instituted, so that the patient does not develop acute gastric retention, which may end fatally.

THE EVALUATION OF NEUROPSYCHIATRY*

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CINCINNATI

A FEW weeks ago I was visiting in Madison, Wisconsin. I was driving along the shores of Lake Mendota with a colleague who told me about a young chemist on the faculty of the University. It seems that this fellow, by dint of hard work and much privation, had recently earned his Ph.D. degree, and he was proud of it in a more than ordinary way. He reveled in his new title of "Doctor" so much that he listed himself as "Dr. Smith" in the telephone book. One evening he and his wife were giving a small dinner party at their home. The meal was well along, and had gotten to that state of silence which comes with a well-filled belly. At that point the telephone rang, and his new Swedish maid, a country girl who had never been encouraged to answer the phone, could be heard to say, "Hello —— Yass, this is Dr. Smith's house —— Who you say you are? —— Oh, yass, Mrs. Brown on Fifth Street —— oh, so your baby is sick? That's too bad —— what? Oh no, Dr. Smith isn't a baby doctor —— oh no, Dr. Smith doesn't go to peoples' houses like that when somebody's sick ——," and then after a pause came the final explanation, "But Mrs. Brown, you don't understand about Dr. Smith. He's one of those doctors who never does anybody any good!"

Until very recently the general opinion of the neuropsychiatrist was that he fit into Dr. Smith's classification—that he never did anybody any good. This is still the opinion widely held, within the profession and out of it. On the other hand, as a result of much which has been written, especially in the war years, and especially in the slick magazines, a contrary opinion has been voiced to the effect that the neuropsychiatrist is a modern miracle worker, that he can accomplish anything within the imagination of man. Where does the truth lie? What do we actually do in this vast field of medicine? What have we learned in recent years? What are we likely to learn in the near future. What can't we do? What are our limitations and what have been our failures?

A question worthy of an answer at the outset is this: How much is there to be done? What is the neuropsychiatric patient load? I quote Stanley Cobb's figures for 1943 which appear to be accurate and simply stated. He found that there were in the United States:

a. Seven hundred thousand mentally disordered patients in institutions.
b. Of these, 100,000 were "aments," i.e. lacking in mind and always had been.
c. Six hundred thousand were mentally diseased, or "dements."
d. In the community he concluded that there were three to five millions in the same category, of which half were "aments" and half were "dements."
e. He found 6,000,000 persons in the "borderland" group of neuropsychiatric disorders. In this group he placed 650,000 epileptics, 1,200,000 stammerers, 1,500,000 alcoholics, 2,500,000 psychoneurotics, and 600,000 "other neurological" disorders.

This adds up to roughly 10 per cent of our population, and it is interesting that Brigadier J. R. Rees of the British Army came to a similar figure. He spoke of there being a "psychopathic tenth" in the recruits of the English forces in the recent war. Undoubtedly, the greatest single problem facing the medical profession is the neuropsychiatric patient.

There is an attitude in occidental civilization which cannot be denied. As deep as any belief in our culture is the belief that it is shameful to be mentally ill. I am certain that many actually believe that mental illness is sinful, and that many more believe that it is self-inflicted, and that the patient is justly deserving of his affliction. These beliefs do not seem to stem from the teachings of our two great Western religions, the Christian and the Jewish, and yet they are there in all of us, to a greater or lesser degree.

In the evaluation of neuropsychiatry I would place this attitude or belief at the top of the list of the limitations of this branch of medicine. The consideration of shame makes the family hide its mentally ill members from view, and even from the doctor's view so that these patients often come under professional observation quite late in their illness. The consideration of shame makes the public apathetic about the care of the mentally ill to the extent that they do not rise up in righteous indignation as they should at the thought that some of our state hospital systems spend more money on soap than they do on the professional care of patients. The consideration of shame often provokes active hostility in those close to the mentally ill patient, making them unco-operative even in such matters as providing an adequate history, and thus impeding good medical practice. Lastly, I have the uncomfortable feeling that this attitude of shame which so often has surrounded

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mental illness has acted as a deterrent against many a good young doctor going into this branch of medicine.

In recent years there have been a series of antidotes against this cultural belief of ours which makes us look on the neuropsychiatric patient like our medieval ancestors looked upon the leper. The establishment of Departments of Mental Hygiene in most of our states, the constant efforts of The National Committee for Mental Hygiene, the work of the United States Public Health Service, the sincere efforts of the Army and Navy in the recent war to provide adequate care for their mentally ill patients, the plans afoot and in progress in the Veterans Administration, and the increasing number of mental hygiene clinics in our larger cities and universities are all portents of a better day. To this may be added the progressive willingness of such private agencies as the Rockefeller Foundation and many others to foster research and training in neuropsychiatry, and the passage of the Priest Bill by the last Congress to provide $25,000,000 for the same purposes. Another salutary sign is the work of responsible journalists, such as Alfred Q. Maisell, whose article in *Life* magazine, "Bedlam 1946," should assist in shaking the public out of its lethargic lack of interest in State Hospital affairs. Although the breeze may be a light one, we are no longer becalmed, and it seems to be freshening. Soon we will be able to carry more sail and make a better course.

Granting, then, that roughly one-tenth of our population has some sort of neuropsychiatric illness, and granting that we are prejudiced against these patients as a matter of cultural belief, let us take Dr. Cobb's groups and evaluate each of them.

AMENTS

For the aments, those lacking in mind from their birth, we have done practically nothing, as we all know. A few interesting facts should be noted, however. All scientific knowledge begins with classification and sorting of the material for study. This has begun in the two or more million mentally deficient. The cretin and the mongolian idiot have been sorted out as has the tuberous sclerosis patient, and a few others. Recently it has been demonstrated that a small group of the remainder have phenylpyruvic acid in their urine. This substance is a metabolite of brain function, and in the normal human is broken down into urea and excreted as such. It is not much progress to boast about, but these cases may be an opening wedge into a greater understanding of the physiological chemistry of this problem. Another group of mental deficients are obviously biologically deficient. They have a high incidence of hare-lip, cleft palate, spina bifida, and visceral anomaly. They are looked upon as accidents of embryology. In all humility, I often wonder that there are so few patients of this type. When one stops to consider the amazing series of events which transpire from the time of the insemination of the ovum until parturition nine months later, he is filled with awe. Very little attention has been paid to this vast field. Perhaps I am talking about the stuff of dreams, but maybe the day will come when we have a medical discipline called clinical embryology. Dream stuff or not, I do not look for any great progress in the care of the mentally deficient patient until such a study is pursued.

DEMENTS

The next group is the dements as distinguished from the aments. These are the patients of sound mind who become sick in mind. They are of concern to all of us as physicians. The first large group are the schizophrenics or the dementia praecox patients. I should like to say a new word about the etiology of this disorder. It has been reported by both the Army and the Navy that there were no more of these cases among service men during the war just ended than might have been expected of a similar group in peace time. This is an important statement because it tends to invalidate the notion that emotional stress causes schizophrenia. Those of us who were in military service, especially in the active theaters of war, saw hosts of men under maximum stress, and yet true schizophrenia was rare among them. This is apparently a disease entity as much as is lobar pneumonia, and I predict that in the not-too-distant future its exact nature will be made known.

In the meantime, the shock therapies have done an impressive job in these cases. Insulin shock, introduced little more than ten years ago by Sakel, metrazol shock introduced about the same time by Meduna, and electroshock which evolved even later out of the work of Cerletti and Bini, have proved efficacious in alleviating the symptoms of 60 per cent to 70 per cent of these cases if gotten early. Please note that I "hedged," that I did not use the word "cure." Even though good remissions are obtained, the illness has a tendency to recur and to necessitate a repeated course of therapy. This is not a valid argument against these therapies. They should be looked upon like surgery and radiation are in carcinoma, as being curative on occasion, palliative on occasion, unsuccessful on occasion. Success occurs in inverse proportion to the duration of the illness.

In recent times electroshock has become more popular and has almost completely replaced metrazol. Insulin is used to a lesser degree than electroshock, but no generally accepted criteria are available to guide us in the choice of one or another of these methods in the individual case. Because electroshock is less time-consuming and less costly, a pragmatic approach has been evolved by many clinicians to try it first, and insulin therapy second. Sargant and his co-workers in England believe that insulin is indicated when weight loss is great, and this appears to have validity. As

the techniques have improved the treatment mortality rate has dropped to near zero and complications have been fewer. Although these therapies have been in use for only a decade they are a real contribution to the treatment of schizophrenia and are deserving of trial. They are certainly not the final answer, however, in this obscure disease. Perhaps one of the most tangible assets to come from their use has been the quickening of interest in the entire subject. The fact that this relentless affliction can be altered at all has attracted investigators from many medical fields to study these patients, and this study should bear fruit.

The next of the dementias is the group of mood disorders, mania, melancholia, involutional melancholia, and the cyclic manic-depressive psychoses. Here the strides have been great. By the employment of the same electroshock therapy discussed above, these disorders can be improved dramatically. One of the most pitiable sights in medicine is the tense, sleepless, muddled, tearful, self-accusatory, miserable person to whom suicidal ideas come as the only welcome way out of his or her difficulties. Before the advent of the shock therapies the psychiatrists had to stand by and watch this torment expend itself over a period of months or even years until some semblance of normality returned. Now this is changed. Often after one or two shock treatments these patients begin to mend. A lucky few need only three or four, others as many as ten or twelve, but 90 per cent or more can be treated successfully. This is a great boon to psychiatry, and is the best news in this report. It is heartening to change a long, tedious, chronic illness, with the ever-present danger of suicidal death, into an illness of a duration measurable in weeks. It must be stressed, however, that electroshock therapy is a treatment for the attack, and that it does not have prophylactic value against a recurrent attack years later. Despite this, the therapy is most welcome to the psychiatrist.

We do not know what happens in the brain when we give this treatment. There has been much theorizing, but none of it has been convincing. It is my prediction that as our theoretical knowledge grows, there will be technical modifications in this therapy, and I do not believe that it is too much to expect that the day will come when the benefit derived from these electrically-induced convulsions will be analyzed, and that results will be obtained without the necessity of producing actual convulsion. That will be a happy day in neuropsychiatry.

We have discussed schizophrenia and the manic depressive states and you have listened to some rather optimistic statements about them. Lest you think I am too enthusiastic, let us turn to the Army results in the recent war. In this vast test-tube of human behavior, the psychotic was recognized early and treatment followed as a matter of course. Practically all the psychoses in the Army were either schizophrenia or manic-depressive psychoses because of the age group involved. We are told that 70 per cent of patients so diagnosed and treated are out of the hospital and either at home or at work as of June, 1946. This is a real mark to shoot at. If we in civil practice could do as well, we would be far better doctors.

Before leaving the subject of these psychoses, a passing word should be given to prefrontal leukotomy, the surgical procedure in which the white matter of the hemispheres is incised, severing the majority of the connecting fibers between the frontal lobes and the remainder of the brain. There appears to have been 1,000 or more of these operations performed in the United States and England since Moniz introduced the procedure. The operation continues to find favor, and should be considered in desperate cases of severe aggressive schizophrenia with destructive or homicidal behavior, in cases of intractable melancholia, and in cases of incapacitating obsessional states, after other therapies have failed. The experience of Freeman and Watts, which is the largest in this field, indicates that the operative mortality is less than 3 per cent, that complications are relatively few, and that the majority of patients are benefited. Given a patient, for example, who must be restrained continuously, who tries to choke the nurse or attendant if he gets free, who rips his clothes from his body, who spits food into the nurse's face, whose screams can be heard in the next ward, and who has been unresponsive to shock therapy, prefrontal leukotomy should be considered. It may change him into a placid, quiet, somewhat dull individual, incapable of mental life at the highest levels of planning or executing plans, but this is often a welcome change in behavior from what he was before.

There are also the organic psychoses to consider among the dements. Syphilitic brain disease was the first psychosis to be treated actively, following the discovery of the malarial treatment of general paresis by Wagner von Jauregg. In the past twenty-five years this technique has been altered repeatedly. At the present time a combination of penicillin with artificial fever therapy, with or without bismuth, is advocated and seems to be the treatment of choice. With the advance of chemotherapeutic knowledge we may expect progressive changes in techniques of treatment of this disease.

SENILE BRAIN DISEASE

The other great segment of the organic psychoses is that of the senile and arteriosclerotic brain diseases. Nothing is accomplished with these patients beyond palliative measures. The challenge which they present is the challenge of the aging process, and this is the concern of the medical profession in general. There is a growing interest in geriatrics on all sides. Not the least is the recent prodding of George Bernard Shaw who insists that we should live to the age of 300. The Sage of Adelphi Terrace has always taken a dim view of our profes-

sion, but I dare say that if anyone ever proves him to be right it will be the doctors.

EPILEPTICS

We now turn to what Cobb has called the borderland of psychiatry. First on the list are 650,000 epileptics. What of these? This part of the report is optimistic. The development of electroencephalography has been a great boon in diagnosis and to some extent in management. The refinements in neurosurgical diagnosis and treatment have assisted materially in singling out those cases with organic basis. The discovery of the anticonvulsant drug, sodium diphenyl hydantoinate, or dilantin, by Merritt and Putnam, has brought relief to hosts of epileptics. The American League Against Epilepsy works unceasingly to take the curse off the disease in the public mind. New anticonvulsant drugs are being studied constantly. Merritt has studied the anticonvulsant action of 700 compounds in the laboratory. We may prepare to hear about a great many new compounds in the treatment of epilepsy in the next few years. This newer pharmacologic knowledge began in 1936. Much has been done in the last decade, but much more can be expected in the next.

Cobb's next group is the stammerers, 1,200,000 strong. I know very little about this disorder and do not regard myself as competent to discuss it. However, as far as I can see we know very little about these patients, and what is done for them is accomplished only after a great expenditure of manpower hours.

ALCOHOLICS

The next are our million and a half alcoholics. I find that I know a great deal about these people because I see more than my share of them, but I know very little, if anything, about their disorder. I think most of my colleagues are in the same fix. No medical regime can honestly claim more than a small per cent of cures in these unfortunate cases. The patients themselves have done far more than their doctors ever accomplished. Alcoholics Anonymous has been a surprisingly successful form of group psychotherapy. A colleague of mine got interested in the movement because his wife was an alcoholic and was benefited by the organization. He studied the doings of one chapter over a three-year period and found that approximately 50 per cent of the members refrained from alcohol in that period. The alcoholic of normal or better-than-normal intelligence who wants to get well and who is not too unstable has a good prognosis with "A.A." The neuropsychiatrist finds this far better than his dismal efforts to date.

PSYCHONEUROTICS

Cobb's next group are the 2,500,000 psychoneurotic patients. He admits that this figure is a guess, and is probably conservative. This group of patients is an ever-increasing challenge to medicine. As medical science improves generally, our patients ask us not only to help them in time of grave illness, but to keep them fit and free of minor complaints. Many of these so-called minor complaints we are called upon to treat are in the realm of what has come to be called the psychosomatic disorders, and are in fact manifestations of a psychoneurosis. Everyone who practices medicine in any form treats psychoneurotic patients and treats a large number of them successfully; others are often unresponsive even in highly skilled hands. The theoretical controversies in this field are many and I do not propose to discuss them. I believe that everyone now recognizes the major contribution of Sigmund Freud and his co-workers in developing the evidence that psychic traumata are often repressed and that such repression leads in many instances to the development of a neurosis. Some of the early contentions of Freudian schools, however, have not stood the test of time. The need for formal psychoanalysis in many cases is no longer insisted upon, even by leaders in the field. For example, Alexander has recently pointed out that many patients can be relieved of their symptoms with a much less time-consuming technique. Although psychoanalysis, which costs the patient as much as the purchase of a small house, can never be adopted generally because of limitations of money, time, and available physicians, this school has imparted to psychiatry a rich, dynamic point of view and has made us all more cognizant of the fact that our bodily functions are in great measure based upon our mental state.

The recent war deluged medical officers with the problems of the psychoneurotic, and I believe that it is fair to state that some things have beer learned from this vast clinical experience. The first is the case of the true neurosis of combat which gained the names of combat fatigue, combat exhaustion, and flight fatigue. One of the things we learned was that every one of us has a breaking point; that if enough emotional and physical stress is applied we are all capable of developing neurotic behavior. The treatment of this large group of cases was one of the outstanding efforts of the war. It was realized that actual fatigue played an important part in the development of these conditions, and that rest and a short period of removal from the stress which produced the neurosis very often brought about the cessation of the disorder. In the European Theater of Operations we followed the technique advocated early in the war and expounded in Circular Letter 176 of the Surgeon General's Office. These patients were placed in a deep sleep by massive doses of barbiturates, often in the combat area, and were kept asleep for as long as from two to three days. When they awakened it was found that the rest and what might be called figuratively "splinting of the brain" produced by continuous sleep permitted approximately 50 per cent of these patients to return to duty.

Of those evacuated to the rear we were impressed with the large number who had lost tremendous amounts of weight, and we noted that when the weight loss was critical these patients were unable

to recover. We were eager to replace their weight as quickly as possible and therefore we adopted the method of Sargant and Slater of giving doses of insulin varying from 40 to 100 units on an empty stomach each morning. This produced drowsiness rather than coma, and when they were fed, three hours later, they ate prodigiously. It was found that these patients often gained weight at the rate of from one-half to one pound a day and when their weight returned to normal their symptoms of neurosis often vanished. Thus we rediscovered Weir Mitchell who found the very same thing more than eighty years ago in the Civil War. Our only addition was a technical one. Mitchell put them to bed in a semi-darkened room and fed them cream and eggs. We put them to bed, gave them insulin to produce an abnormal appetite, and then fed them Spam and C Rations. This regime proved to be of special value in the gastric neuroses. It is possible to translate these experiences into civil practice.

The war demonstrated as well that there is often a constitutional factor in the neurosis patient, that some people seem to be born with a nervous instability. Freud would call these the character neuroses, and they are relatively unresponsive to treatment by any method. They cannot stand the stresses of ordinary life on life's own terms, and they must be segregated into an environment relatively free of stress. It was found by Eysenck, a British investigator, that these constitutional tendencies toward nervous instability occurred at both ends of the range of human intelligence. In other words, the dull-witted and the excessively brilliant soldier were equally prone to a neurotic breakdown under stress, whereas those in the middle range of normal intelligence were least likely to be constitutionally disposed toward neuroses.

Another lesson was that of group psychotherapy which was used on a wide scale in military life. It was found that soldiers who had been through acute neurotic illness were made better if they were given some simple explanation of the causation of their bodily disturbance as a result of emotional stress. Because everyone was in a hurry, this was often done in groups and it was found that it was much easier to perform this function in a group atmosphere. This, too, will probably be translated to civil practice in many places.

Lastly, it was found that a short cut could often be employed for getting at those disturbing psychic experiences which are repressed in the unconscious of patients with tramautic neuroses by using intravenous barbiturates, especially sodium pentothal. It was found that one could get to the core of the difficulty which the patient had bottled up within him in a matter of a few hours rather than spending months in laborious psychiatric interviews. This technique has come to be called narcoanalysis, narcosynthesis, chemical hypnosis, or drug ventilation. It is in its infancy and when more is learned about this procedure a new tool will be given to the physician in the handling of the neurotic patient.

PSYCHOPATHS

Finally we turn to Cobb's classification of "other neurologic cases" in which he numbers 600,000. This is undoubtedly a conservative number, especially if the group of psychopathic personalities be included in this category. The homosexuals and the other types of sexual perversions have not been helped by the neuropsychiatrists. Interesting biochemical studies have been started in this field, but no therapeutic tools have been found. The psychopaths of the criminal type, aggressive type, and the antisocial type ordinarily do not come to the physician's eye, and he knows them only as the bad boys in the neighborhood. Psychiatrists have been trying to understand more about these social misfits, and the beginning of progress can be recorded. Some investigators find that these patients often give a history of inflammatory brain disease or of brain trauma in youth and that they have abnormal electroencephalographic tracings. This has led to the use of anticonvulsant drugs in some of these patients and to the search for other drugs which may improve their brain wave patterns. It is too early to report much success in this field but work is in progress.

NEUROLOGIC DISEASE

Finally, let us quickly run through the list of "other neurological disorders." The most prevalent one is multiple sclerosis; no progress can be reported in this unfortunate illness. The same is true in the group of myopathies and neuropathies, those queer, progressive disorders of muscle and nerve which produce relentless muscular weakness and wasting, and end in early death. We have nothing to offer these patients at this time. A somewhat allied condition, myasthenia gravis, has responded well to the use of prostigmin. Parkinson's syndrome has not yielded any new secrets in recent years beyond the drugs of the atropine series which are only partially successful in alleviating these patients and seem to have no effect in preventing the forward progress of the disease. The spinal cord changes in pernicious anemia have responded to liver therapy, and that odd condition known as narcolepsy has responded to drugs of the benzedrine group. Meniere's Disease can be alleviated in a great majority of cases by potassium chloride. Interesting work is in progress in the treatment of the birth palsies.

A large list of neurologic disorders would be tedious, but it is fair to state that the whole point of view of investigators has changed regarding these illnesses. In times past the brain was looked upon as a mysterious, inert, mushy mass, but in recent years it has come to be realized that it is the most reactive of all the tissues in the body, and is therefore more amenable to therapeutic agents than any other. In other words, the note is

one of hope and daring and it is probable that we will see continued successful efforts in the years ahead.

SUMMARY

In summary, I should like to add up the score:

1. The large group of amentias, those patients who are lacking in mind from birth onward, have defied our efforts.

2. Of the dementias we have made great progress in the handling of the manic and depressive states, some progress in the handling of the schizophrenic, and continued progress in the handling of the luetics.

3. We have accomplished nothing for the senile group.

4. The epileptic has received great benefit by drug therapy in the past ten years, and by pharmacological advance and improved methods of diagnosis more can be expected in the near future.

5. The alcoholics continue to defy us.

6. The psychoneurotic is a major problem but the war experience will probably lead to a better therapeutic approach to this vast group of patients.

7. The psychopath is being studied with increasing intensity and it is fair to hope that some gains will be made in the near future.

8. The patient with organic neurologic disease is being studied more intensively each year by a large group of investigators with steadily encouraging results.

No honest evaluation of neuropsychiatry can be given without a closing statement about one of the most troublesome problems in this branch of medicine. Emerson has said that no institution is greater than the shadow cast by its tallest men. How many tall men have we, or, to pose an even better question, how many men have we? The answer is that we have far too few, and we are seldom recruited from the outstanding graduates from our schools. Advance has been great, but would be far greater if there were more and better doctors in the specialty. At the present time it is not uncommon to find 400 or more patients under one doctor's care in mental hospitals. This is an absurd state of affairs, and real progress cannot be expected unless the situation changes. There are signs of that change. Dr. Forrest Harrison of the National Committee for Mental Hygiene reports that he cannot begin to fill the requests for resident training in neuropsychiatry among the men coming out of military service in search of such training. There is a dearth of teachers. There is a dearth of training centers. But neuropsychiatry, long isolated in out-of-the-way state hospitals, now has something to offer, and is coming to town to assume its place at the side of medicine and surgery in our hospitals. I predict that within ten to fifteen years no general hospital will be fully accredited unless it has provisions and staff to take care of the mentally ill who knock at its door, in the same efficient manner in which it now takes care of its medically and surgically ill. The hospitals owe this service to the community. The trend in this direction which is going on all about us will provide more teaching facilities, will give the student and the intern a better chance to observe modern neuropsychiatry, and will ultimately solve the problem. The quickening of interest on the part of the schools, and the program of graduate training in the Veterans Administration under the aegis of your famous fellow-Indianian, Major General Paul R. Hawley, are signs which point to a better day for the neuropsychiatric patient.

Convention Notes

(By barbed wire from Orange County)

THE INAUGURAL FROLIC on Tuesday night will be a cavalcade of fun for the doctors, their wives and families, presenting an exceptional array of talent, featuring as Master of Ceremonies JACK SHEA, "The Mad Auctioneer," the comedy high light of Olsen and Johnson's "SONS O' FUN."

AMERICAN MEDICINE HONORED INDIANA by selecting Roscoe L. Sensenich, M.D., as the president-elect of the American Medical Association. Dr. Sensenich will be guest of honor and speaker at the annual convention banquet on Thursday night. "All out for Sensenich."

ATTENTION GOLFERS! The French Lick Springs Hotel will sponsor a big, three-day, pro-amateur golf tournament on the Friday, Saturday, and Sunday following the Indiana State Medical Association Convention, October 31, November 1 and 2. This time has been especially arranged for the doctors who wish to stay over the week-end and participate in this big sports event.

THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

OUR PRESIDENT

FLOYD TROUTMAN ROMBERGER came to Indiana from Pennsylvania, where he was born in 1887. His family was of old "Pennsylvania Dutch" stock. A lot of our younger members probably know little about these folk, many of whom came to Indiana in the early days, most of them "settling" in Northern Indiana.

"Rommy," as he is known to thousands of Hoosier medical folk, had his early education in Pennsylvania, receiving his B.S. degree in 1905 from Albright College, in Reading, and his M.D. degree from the University of Pennsylvania, in 1909.

For some eight years he was in general practice, then in the Army, as Medical Corps captain, for two years during World War I. In October, 1919, he came to LaFayette and at once limited his practice to anesthesiology, being rated as an Indiana pioneer in this field. He headed this department in both St. Elizabeth Hospital and LaFayette Home Hospital.

Through all these years, since graduation from medical school, he has been extremely active in all phases of organized medicine. A member of the county, state, and national organizations, he also is a member of the three special societies of his specialty, including that of being a Diplomate of the American Board of Anesthesiology. He has served as the head of his local county society, the head of the two hospital staffs, and as head of the Mid-West Society of Anesthetists.

He has been a member of the Indiana State Medical Association House of Delegates since 1925, that being the year of our first active acquaintance with him. We recall that, as we presided over the sessions of the House that year, this young chap came into the meeting place early and took a seat right down front. He did not want to miss anything and it has been our observation that in the twenty-two succeeding years Rommy has missed exactly nothing.

He has held numerous offices and appointments in association affairs over the years, spending fifteen years as Councilor of his Medical District, five of these years as Council Chairman. He was named as President-Elect for 1946 and during the current year has served as the official head of this organization.

He is of the Methodist faith, a stanch Republican, and a Mason.

In 1909 he was married to Miss Laura E. Enders, and they have two children—Floyd, Jr., M.D., of Indianapolis, and Phoebe E., physiotherapist in Youngstown, Ohio.

Thus we have the early and the medical history of our President, but this is by no means all of the story. Rommy has done a good job for the medical profession over the years, especially in Indiana. We have watched him through all his activities, have known him intimately, and have had many conferences, including not a few arguments, with him in this time.

Rommy is not "quick on the trigger," he is wont to say, "Wait a minute, I want to think about this." Then comes his answer.

The Indiana State Medical Association has been blessed with many good leaders, but we unhesitatingly put Rommy right at the top of the heap. He has done a lot of work—and done it exceedingly well!

HYPERTENSION

OF FIRST priority on the list of causes of physical disability is hypertension, or hypertensive cardiovascular-renal disease. This is not primarily a vascular disease but a definite syndrome caused by kidney dysfunction. It manifests itself in hypertension, cardiac hypertrophy, secondary degenerative changes in the kidney itself due to the circulatory changes, and degenerative changes in other organs, including the brain. Malignant hypertension is merely a severe and terminal stage of the process.

In evaluating the blood pressure, the diastolic is the important factor. A persistent diastolic of over ninety is considered abnormal. Blood pressure may be evaluated most truly just before or after the patient arises in the morning, or while he is asleep. A normal size heart is found with the volatile type of hypertension. An enlarged heart is indicative of a chronic progressive disease. The eyeground picture reveals the state of the capillaries. Concentration tests of the urine will tell the condition of the kidneys. Blood pressure readings alone should not be the sole criterion for the severity of cardiovascular-renal disease.

In the management of real hypertension, the commonly used bromides, barbiturates, and potassium thiocyanate are not effective enough. Properly done sympathectomy is a severe and radical treatment not on a generally recognized basis. It does not attack the cause of the disease. Its best use is for the malignant type of disease.

At present, the most gratifying relief of the symptoms of headache and jumping out of one's skin, together with the reduction of the hypertension without danger and great expense, is the maintenance of the sodium chloride in the food to approximately 1.2 gm. a day. With such a low sodium intake the fluid intake may be as liberal as desired. The sodium intake can be checked by the chloride content of the urine. It is essential to keep up the protein intake. Many proteins are rich in sodium. Protein foods extremely poor in sodium are being prepared commercially. With the relief obtained by such a dietary regimen, cooperation of the patient may be expected.

In the meantime, the important search for the specific underlying cause of the kidney disease will go on.

PURDUE FIELD HOUSE DISASTER

FOLLOWING the collapse of sections of the bleachers in Purdue Field House, during a basketball game, last February 24, which resulted in two deaths and hundreds of casualties, considerable interest was manifested in how the emergency was met; just what part the medical profession of the community played, as well as the Purdue Student Health Service and the two local hospitals. It was realized that LaFayette is not overly supplied with physicians and that there are but two hospitals located there and, as in all other hospitals at this season of the year, the bed capacity was pretty well filled.

A few days after the accident, stimulated by a number of inquiries received from over the state, we contacted President Floyd T. Romberger, asking for such information as he might be able to send us. He replied that the local medical society preferred to handle the matter and that a local committee would make a report, later on. This we have received, comprising a report from each of the two hospitals, one from the Student Health Service, and one from Dr. Ash, of West LaFayette.

Emergency first-aid treatment was given at the field house, the Student Infirmary, the Student Health Clinic, the Woman's Residence Hall Infirmary, and in Cary Hall, East. The total number of such emergency treatments at these five points was 402.

Dr. Miller, Director of Student Health Service, reports that this group was cared for chiefly by doctors, nurses, coaches, staff members, and students. Later on, many of the casualties reported for further treatment, over 1,500 treatments being given at the Student Health Service over a period of about two weeks.

Seventy-five per cent of all accidents treated at the infirmary were of the lower extremities; contusions, with and without hematomas, were the most common type of injury.

The LaFayette Home Hospital admitted 49 patients, in addition to 37 who came in for x-ray examination only. One of the patients died, the cause being given as chest injury together with fracture of the right tibia and the left humerus.

Forty-nine patients were hospitalized at St. Elizabeth Hospital, 62 were seen in the outpatient department, and 276 were given x-ray examinations. There was one death in this group, the cause being recorded as ruptured heart.

To medical men probably the most interesting thing is the speed with which the whole relief plan was organized. As Dr. Ash says, the first thing to be done was to rescue the several hundred victims from underneath the debris. The more seriously injured were carried out on stretchers and improvised litters. An announcement was made over the public address system that no one was to be moved until he had been checked by a physician.

Medical supplies, including splints, became available, thus expediting matters to a high degree. The more seriously injured, including all compound fractures, were given an injection of morphine and the letter "M" was painted on the foreheads of these cases. Ambulances were at a premium, so closed body laundry trucks were pressed into service.

So, in brief, is the story of a small group of physicians and nurses, assisted by a lot of citizens possessed of plenty of common sense, in meeting an emergency of huge proportions.

The local medical group, Purdue University officials, as well as the townsfolk, deserve the highest credit. After all, it is a matter of *organization;* there must be a lot of level-headed folk to take charge, to give orders, and to see that they are carried out—this all was done and done exceedingly well.

Editorial Notes

Dr. Charles W. Myers, Superintendent of Indianapolis City Hospital, has recommended an increase in pay for his nurses to the extent of $65.00 per month. Various other employes are included in his recommendation for salary increases. His budget for the coming year amounts to well over two million dollars, quite a sizeable sum for a city charitable institution. We often have wondered just how much of this could be saved were the hospital closed to all but the worthy poor!

The Monroe County Medical Society, one of the really live organizations in Indiana, now has under consideration plans for the hospitalization of polio cases, at present there being no facilities for such in the county. Even with the new twenty-five-bed addition to the local hospital there is no present space available for polio cases. At a recent conference with State Health Director Burney, it was suggested that it might be possible to secure funds for a district hospital to care for these and other contagious cases.

The Sullivan County Medical Society "makes" Hygeia magazine, as a result of its program, begun in 1937, to make Sullivan County diphtheria-free, with more than 9,000 inoculations in the past ten years. And, the best part of the story is that the campaign still is being waged, with the result that there have been but four cases in the county, with no deaths. For the ten-year period prior to the campaign there were 109 reported cases, with 19 deaths. Yet with such figures available there still remains quite some opposition to a wholesale program of immunization.

Surgeon General Thomas A. Parran, of the United States Public Health Service, recently commented on the fact that there are five times as many civilians handicapped through accident and disease than were noted as a result of the recent war. He estimates that an average of 200,000 civilians annually are thus handicapped and, of course, strongly recommends that our rehabilitation program include them, as well as the veterans.

Like Banquo's ghost, the idea of full-time county health officers will not down—nor should it down, since it is one of the most important health measures ever planned. We note two such plans, each of which seems about to be consummated. Down in Southern Indiana we learn that Floyd and Harrison Counties already have such a plan well under way, with our old friend, Dr. Amy, of Corydon, as full-time health officer of those two counties.

Over in Vigo County the proposed plan is much more pretentious, as might be expected due to a much larger population. The Junior Chamber of Commerce, one of the up-and-coming of the newer organizations in Indiana, has put its shoulder to the wheel, has made a preliminary survey, and has recommended a definite plan whereby this may be brought about.

Briefly, the plan would be headed by a seven-man, nonpartisan board, three of whom shall be practicing physicians. The Indiana State Board of Health is expected to make a sizeable donation to the original fund and, once the plan is in operation, to make it a sort of "guinea pig," that is, the Board will use the setup as a training school for other counties.

Being health minded, it seems to us, is but a matter of education; properly placed before the citizens of a community there should be little trouble in "selling" the idea. It is not a matter of a short, one or two week campaign; however, it is a matter of constantly plugging along for an improvement that will be of benefit to every citizen of any particular community.

There is of course one thing that must be borne in mind, that the local medical group should be consulted on every move made; *this is a must.*

President's Page

SO THIS IS FRENCH LICK

EDUCATION—ENJOYMENT—ENTERTAINMENT

EDUCATION. There will be instructional courses for those interested. Many theses will be presented by learned physicians from within and from outside the state, covering a large variety of medical topics. There will be open forums and round-table discussions. Perhaps, too, you may be able to learn something by just sitting and talking with mutual friends about your problems. It has been known to happen.

ENJOYMENT. Do you enjoy golf? Riding? Hiking? Horseshoe? Croquet? Tennis? Skeet? Bowling? Just settin' on the porch, rocking? Pluto or corkage? Playing with one-armed bandits? Gaming devices? Baths and massage or just resting? Visiting with friends? Lively conversational exchange? Music? Dancing? Scenery? Singing birds? Lovely, varicolored foliage? Hey? Just what DO you enjoy? In your own tightly circumscribed world? LIFE and LIVING consist of living the life of your contemporaries, your buddies, your friends. A wit once remarked: There are but two consolations for self-love: (a) you never will be sued for breach of promise, and (b) you needn't pay alimony.

ENTERTAINMENT. Discrete and lively. For all—all the time. Even while you eat the good meals graciously served. Hearty laughs are promised. Hear about the doctor who diagnosed the case by the feel of the purse. And the one who suffered good health—his community was too well. Then there was one, also, who found that at French Lick dough did not stick to his fingers. There's just no predicting the old and corny jokes and stories one may hear at a convention. More practically speaking, how many of your friends, including yourself, never or seldom attend our annual meeting? Do they really know what they are missing? I have my sincere doubts. These trying times of today might be the good old days we'll long for tomorrow.

WORK

Because of the many accomplishments attained during the year by the Executive Headquarters, the Official Family, the Standing Committees, the Section Officers, the Council and its Executive Committee, this should be a surprisingly smoothly operating annual session. Yet, many of our membership will continue to work, and work hard, right through to the last hour of the last day of the convention. Among these will be the Delegates and the Reference Committeemen. None of them are working particularly for themselves; no, they are working for you, for the honor and glory and prestige of the I.S.M.A. THAT is what has made it GREAT.

REFERENCE COMMITTEES

By-laws, Chapter IX—"Immediately after the organization of the House of Delegates at each Annual Session, the President shall appoint, from the members of the House, reference committees to serve during the session at which they are appointed . . . published in THE JOURNAL and/or Hand Book . . . Such publication shall constitute notification . . . To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates . . . recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection."

Members I.S.M.A., that is democracy at work, as exemplified in your great association. I might add that in no other way can or would the tremendous spread of activities and business of the House receive its due and just attention.

These committees have been selected, the chairman designated, and the whole is published in this issue of THE JOURNAL. Further, each member has been notified personally, by mail. I believe that they are strong committees, able and efficient. Fifty appointments were made. Within seventy-two hours, twenty-four acceptances along with definite promises to be present were received in one mail; forty-six already are in hand (August 27). Physicians of the I.S.M.A., once again I salute you! Money cannot buy, neither could edict nor decree compel such spirit, such co-operation. Yes, you have a GREAT ASSOCIATION! Thanks a lot.

At many annual sessions the amount of work performed by these committees in their hearings and by the House of Delegates when in session is prodigious. It is important! To every one of you! May there be no absenteeism! In accordance with the democratic processes of free men, free physicians, not a single delegate will be denied full opportunity to express his own and/or his county society's wishes and desires. Let's continue to make democracy work!

WOMAN'S AUXILIARY

Nationally your organization is now twenty-five years old; you are celebrating your Silver Anniversary. Congratulations. I predict for you an expanding and increasing role of opportunity and usefulness. Perhaps we of Indiana have overlooked in part your potential value to us; yet you must know that we love you, but, having no professional Dorothy Dix to admonish us, maybe we didn't whisper it softly into your ear often enough. I now do.

It was a happy concurrence of thought when our Executive Committee in its wisdom directed our JOURNAL to provide you with more white space for your activity news and when the Council earmarked a modest fund to aid your organizational efforts. We trust that this perhaps belated help and recognition will be well received and in the same spirit with which it is offered, family-like co-operation in all I.S.M.A. endeavors. You can help us a great deal, in these days of reconfusion, with well directed programs of authentic information to your ladies' groups, to the press, and to the members of our General Assembly. More power to you. You have our blessing. We wish you well.

Floyd L. Romberger

REPORT ON THE INCIDENCE OF HOMOLOGOUS SERUM JAUNDICE FOLLOWING THE USE OF SURPLUS DRIED PLASMA*

THE Committee on Blood and Blood Derivatives of the Advisory Board on Health Services of the American National Red Cross believes that the possibility of disease transmission by the injection of human blood and certain of its derivatives should be re-emphasized to state and territorial departments of health, and through them to practicing physicians within their jurisdiction. Although many diseases theoretically might be so transmitted, homologous serum hepatitis or jaundice following the administration of pooled plasma has proved to be the greatest practical problem; first, because of the difficulty or impossibility of detecting infective donors; second, because of the practice of pooling 10-50 bloods to reduce the isohemagglutinin titer; and third, because of the availability of dried plasma as a result of the distribution of surplus blood derivatives by the American Red Cross.

In the instructions for the use of *Normal Human Dried Blood Plasma* attention was called to the possibility of virus transmission under the section headed *Adverse Reactions from the Administration of Human Plasma.* It was emphasized that jaundice might develop from 1 to 4 months after administration, if a particular lot were contaminated with the virus of homologous serum jaundice.

The committee has reconsidered the advisability of distributing this plasma on several occasions, but has always felt that, in view of the lack of availability of whole blood or other relatively safe blood derivatives in many parts of the country, plasma would save many more lives than would be lost from the occasional severe case of hepatitis which might result from its use. At the same time, steps were taken to determine as accurately as possible the real risk to the patient from the use of the surplus plasma being distributed by the American Red Cross. Studies were initiated in several states. One of these carried out by the New York State Department of Health has now progressed to the point where sufficient figures are available for tentative conclusions. In 649 patients followed for 6 months after transfusions of this plasma, 29 cases of hepatitis have been observed, while there have been no suggestive symptoms of hepatitis in 1,597 household contacts of these 649 patients, thus suggesting that the disease actually was homologous serum jaundice and not epidemic infectious hepatitis. This figure of 4.5 per cent thus represents the probable maximum incidence of the disease in recipients of random lots. It is lower than the 7.3 per cent incidence reported in approximately 1,000 patients receiving pooled serum prepared by the Northwest London Blood Supply Depot in Great Britain, but the size of their pools was somewhat larger.

There is every reason to believe that whole blood, fresh or frozen plasma prepared by hospital blood banks, or commercial plasma, as well as convalescent serum, may all transmit the same agent, but the factor of pooling greatly increases the probability factor with plasma. On the other hand, there is good evidence that the two most widely used products of plasma fractionation are free from this risk. In the case of *Immune Serum Globulin* (normal human serum gamma globulin) distributed by the American Red Cross for the prophylaxis of measles, follow-up studies have been made on approximately 1,900 patients. Only one case of jaundice occurred within 6 months of injection and, in that case, 74 other children received the same lot without developing any evidence of hepatitis. In the case of *Normal Human Serum Albumin* (salt-poor) a heat treatment used in its routine preparation has been shown to inactivate a strain of homologous serum hepatitis virus. Various promising studies on methods for inactivation of this virus in plasma are under way, but nothing has been perfected thus far. Finally, there is evidence that the disease may be transmitted from patient to patient in hospitals by the use of improperly sterilized or unsterilized syringes and needles.

This committee still does not feel that plasma should be withdrawn from distribution. However, it does believe that all practicing physicians should be reminded of the potential risk to the patient in the administration of pooled plasma and urged to restrict its use to those instances, chiefly serious emergencies, when its use is clearly indicated and when safer agents such as whole blood or serum albumin are not available. Moreover, physicians who see patients with hepatitis should make a habit of inquiring about their injections with blood or its derivatives during the preceding 6 months and of reporting such cases to the state or territorial department of health.

Patients who have been hospitalized within 6 months and particularly those who have received injections of human blood, plasma, or serum during that period should not serve as blood donors even though they may feel perfectly well. Furthermore, potential blood donors should be rejected if a history of jaundice among members of their household within a period of the past 6 months is obtained.

* Prepared by the Committee on Blood and Blood Derivatives of the Advisory Board on Health Services of the American National Red Cross. The Committee consists of Dr. Charles A. Janeway, chairman; Dr. Elmer L. DeGowin, Dr. Charles A. Doan, Dr. Isidor S. Ravdin, Dr. Robert F. Loeb, and Dr. Edwin J. Cohn. This report distributed by the American National Red Cross, August 15, 1947.

Ninety-Eighth

Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick, Indiana

October 28, 29, and 30, 1947

Headquarters—French Lick Springs Hotel

Complete Program on following pages



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LaFayette

President

Indiana State Medical Association

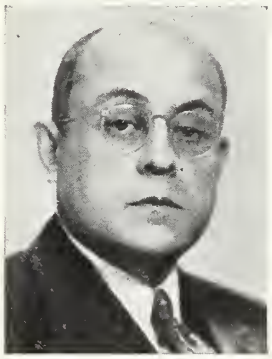
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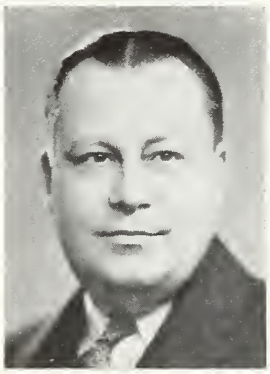
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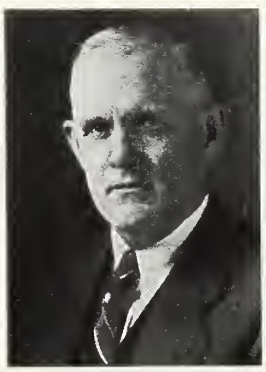
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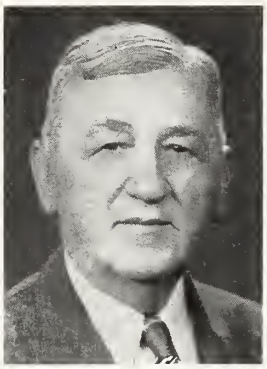
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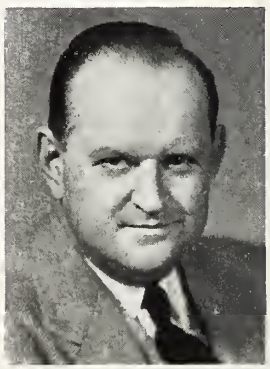
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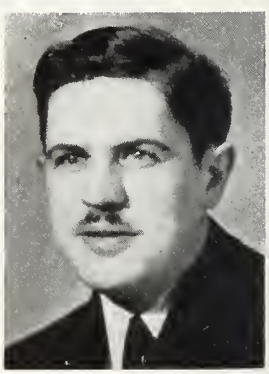
R. R. CALVERT
Chairman
Section on Ophthalmology
and Otolaryngology
LaFayette



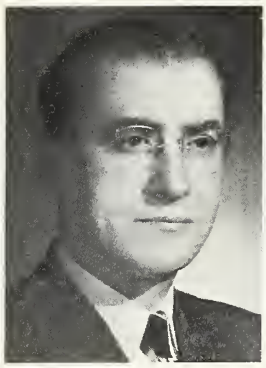
S. L. BRYAN
Secretary
Section on Medicine
Evansville



HAROLD D. CAYLOR
Secretary
Section on Surgery
Bluffton



E. F. BOGGS
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Section on General Practice
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State Medical Association
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F. R. N. CARTER
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South Bend

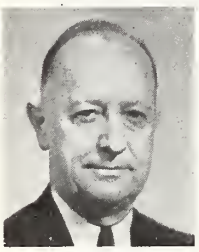


LALL MONTGOMERY
Editorial Board
Muncie



EUGENE L. BULSON
Editorial Board
Fort Wayne

Out-of-State Guest Speakers



WILLIAM S. MIDDLETON, M.D.
Dean, and Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin



HENRY N. HARKINS, M.D.
Professor of Surgery, University of Washington School of Medicine, Seattle



GEORGE T. PACK, M.D.
Assistant Professor of Clinical Surgery, Cornell University Medical College, New York



BRUCE K. WISEMAN, M.D.
Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio



PAUL H. HOLINGER, M.D.
Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago



WILLIS J. POTTS, M.D.
Associate Professor of Surgery, University of Illinois College of Medicine, Chicago



EDWARD B. TUOHY, M.D.
President, American Society of Anesthesiologists, Inc., Washington, D.C.



LOWELL T. COGGESHALL, M.D.
Chairman of the Department of Medicine and Dean of the Division of Biological Sciences, University of Chicago, the School of Medicine, Chicago



ALEXANDER R. MacLEAN, M.D.
Rochester, Minnesota



LEE FOSHAY, M.D.
Professor of Bacteriology, University of Cincinnati College of Medicine, Cincinnati



PHILIP LEWIN, M.D.
Associate Professor of Bone and Joint Surgery, Northwestern University Medical School, Chicago

Official Program

Ninety-Eighth Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick Springs Hotel

French Lick, Indiana

October 28, 29, and 30, 1947

(Schedule will be carried out on Central Standard Time)

Monday, October 27, 1947

Annual Indiana Health Officers' Conference.

6:30 p.m. Executive Committee dinner and meeting, Parlors A and B, main floor.

Tuesday, October 28, 1947

Morning

8:00 a.m. Registration starts, mezzanine floor.

8:00 a.m. Opening of technical exhibit, mezzanine floor.

8:00 a.m. Opening of scientific exhibit, foyer to main convention hall.

8:00 a.m. Annual golf tournament. Eighteen holes, low gross, low net, and blind bogie medal play. French Lick Hill Course.

9:00 a.m. Annual trap and skeet shoot, French Lick Springs Trap and Skeet Club.

11:00 a.m. Editorial Board meeting, Room 143, main floor.

11:00 a.m. Instructional courses.

Afternoon

12:30 p.m. Council meeting, Blue Room.

1 to 5 p.m. Instructional courses.

4:00 p.m. Meeting of House of Delegates, main convention hall.

Evening

7:00 p.m. Inaugural frolic for physicians, their wives and guests, main dining room. Award of golf, trap and skeet shoot prizes.

Wednesday, October 29, 1947

Morning

7:30 a.m. Breakfast meeting of members of the State and County Conservation of Vision Committees, Parlors A and B, main floor.

Speaker: HEDWIG S. KUHN, M.D., Hammond.

8:00 a.m. Breakfast meeting of Committee on Industrial Health, Blue Room.

8:00 a.m. Registration continues, mezzanine floor.

8:00 a.m. Technical exhibit, mezzanine floor.

8:00 a.m. Scientific exhibit, foyer to main convention hall.

GENERAL MEETING

(Main Convention Hall)

10:00 a.m. Call to order by Floyd T. Romberger, M.D., LaFayette, president, Indiana State Medical Association.

10:05 a.m. Greetings by Augustus P. Hauss, M.D., New Albany, co-chairman of Committee on Convention Arrangements, and introduction of officers of Orange County and Third District Medical Societies.

Official welcome by Clarence E. Boyd, M.D., West Baden Springs, secretary, Orange County Medical Society, and co-chairman of Committee on Convention Arrangements.

10:10 a.m. President's address, FLOYD T. ROMBERGER, M.D., LaFayette.

10:30 a.m. WALTER U. KENNEDY, M.D., New Castle. Subject: *Mutual Medical Insurance, Inc.*

SCIENTIFIC PROGRAM

Wednesday, October 29, 1947

10:45 a.m. Symposium on *The Treatment of Burns.*

Moderator: HAROLD M. TRUSLER, M.D., Indianapolis.

HENRY NELSON HARKINS, M.D., Professor of Surgery, University of Washington School of Medicine, Seattle.

Discussion:

Harold D. Caylor, M.D., Bluffton.
Allan Harcourt, M.D., Indianapolis.
Henry W. Bopp, M.D., Terre Haute.
Thomas B. Bauer, M.D., Indianapolis.

11:45 a.m. Intermission to view technical and scientific exhibits.

Noon

12:00 m. Luncheon meeting of members of State and County Anti-Tuberculosis Committees, Blue Room. Indiana Chapter of American College of Chest Physicians participating.

Speakers:

MERLE BUNDY, M.D., director, Division of Tuberculosis Control, Indiana State Board of Health, Indianapolis.

Subject: *Tuberculosis Program in Indiana.*

MURRAY A. AUERBACH, Secretary, Indiana Tuberculosis Association, Indianapolis.

Subject: *The Program of the State Tuberculosis Association.*

Discussion:

Paul D. Crimm, M.D., Evansville.
M. R. Lohman, M.D., Fort Wayne.
Thomas R. Owens, M.D., Muncie.

X-ray conference sponsored by the Indiana Chapter of American College of Chest Physicians.

12:00 m. Reunion luncheon of 1937 class of Indiana University School of Medicine, Parlor A.

12:30 p.m. Veterans' luncheon and meeting. West Dining Room.

SECTION MEETINGS

Wednesday, October 29, 1947

Afternoon

SECTION ON MEDICINE

Chairman, William M. Dugan, M.D., Indianapolis
Vice-Chairman, Maurice E. Glock, M.D., Fort Wayne
Secretary, Stanton L. Bryan, M.D., Evansville

(Main Convention Hall)

2:00 p.m. WILLIAM S. MIDDLETON, M.D., Dean, and Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin.

Subject: *Present Day Management of Thyrotoxicosis.*

2:30 p.m. Questions.

2:45 p.m. BRUCE K. WISEMAN, M.D., Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio.

Subject: *Recent Observations and Newer Practices in the Recognition and Treatment of Leukemia.*

3:15 p.m. Questions.

3:30 p.m. FRANKLIN B. PECK, M.D., Indianapolis.
Subject: *Management of Diabetic Coma.*

4:00 p.m. Questions.

4:15 p.m. KENNETH G. KOHLSTAEDT, M.D., Indianapolis.

Subject: *Management of Congestive Heart Failure.*

4:45 p.m. Questions.

5:00 p.m. Election of Section Officers.

SECTION ON SURGERY

Chairman, Arnold Duemling, M.D., Fort Wayne
Vice-chairman, William N. Wishard, Jr., M.D., Indianapolis
Secretary, Harold D. Caylor, M.D., Bluffton

(North Porch, Main Floor)

Wednesday, October 29, 1947

2:00 p.m. M. B. CATLETT, M.D., Fort Wayne.

Subject: *Surgical Conditions of the Gall Bladder.*

(Wednesday, October 29, 1947)

2:30 p.m. FRANK B. RAMSEY, M.D., Indianapolis

Subject: *Surgical Aspects of Carcinoma of the Thyroid Gland.*

3:00 p.m. GEORGE T. PACK, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York.

Subject: *The Definition of the Inoperability of Cancer.*

3:30 p.m. WILLIS J. POTTS, M.D., Associate Professor of Surgery, University of Illinois College of Medicine, Chicago.

Subject: *Surgery in Congenital Heart Disease.*

4:00 p.m. Election of Section Officers.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman, R. R. Calvert, M.D., LaFayette
Vice-chairman, Robert A. Smith, M.D., New Castle
Secretary, Richard P. Good, M.D., Kokomo

(Game Room, Mezzanine Floor)

Wednesday, October 29, 1947

2:00 p.m. CORLEY B. McFARLAND, M.D., South Bend.

Subject: *Histopathologic Changes in Diabetic Retinitis.*

2:30 p.m. CHARLES L. MAHONEY, M.D., Terre Haute.

Subject: *Headache.*

3:00 p.m. MARVIN P. CUTHBERT, M.D., Indianapolis.

Subject: *Use of Cross-Cylinder in Refraction.*

3:30 p.m. W. REYNOLDS HICKMAN, M.D., Logansport.

Subject: *Periorbital-cellulitis.*

4:00 p.m. PAUL H. HOLINGER, M.D., Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago.

Subject: *Nontubercular Pulmonary Diseases and Their Relation to Partial Obstruction.*

4:30 p.m. Election of Section Officers.

SECTION ON ANESTHESIA

Chairman, Frank W. Ratcliff, M.D., LaFayette
Vice-chairman, William H. Lane, M.D., South Bend
Secretary, Edward F. Bloemker, M.D., Indianapolis

(Parlors A and B, Main Floor)

Wednesday, October 29, 1947

2:00 p.m. Opening remarks, Frank W. Ratcliff, M.D., LaFayette, chairman of Section.

2:10 p.m. WILLIAM B. ADAMS, M.D., Muncie.

Subject: *Anesthesia for Patients with Cardiovascular Diseases.*

Discussion to be opened by Charles N. Combs, M.D., Terre Haute.

2:40 p.m. EDWARD B. TUOHY, M.D., President, American Society of Anesthesiologists, Inc., Washington, D.C.

Subject: *Anesthesia in Abdominal Surgery.*

Discussion to be opened by Floyd T. Romberger, M.D., LaFayette.

3:10 p.m. M. B. FLANIGAN, M.D., Indianapolis.
H. T. MOORE, M.D, Indianapolis

Subject: *Anesthesia in Chest Surgery.*

Discussion to be opened by William H. Lane, M.D., South Bend.

3:40 p.m. New business.

Election of Section Officers.

Adjournment.

SECTION ON GENERAL PRACTICE

Chairman, Claude S. Black, M.D., Warren
Vice-chairman, Clay A. Ball, M.D., Muncie
Secretary, Eugene F. Boggs, M.D., Indianapolis

(North Convention Hall)

Wednesday, October 29, 1947

2:00 p.m.. JAMES C. KATTERJOHN, M.D., Indianapolis.

Subject: *The Treatment of Hemangioma.*

2:30 p.m. Discussion: A. N. Ferguson, M.D., Fort Wayne.

3:00 p.m. LOWELL T. COGGESHALL, M.D., Chairman of the Department of Medicine and Dean of the Division of Biological Sciences, University of Chicago, The School of Medicine, Chicago.

Subject: *The Current Use of Influenzal Vaccines.*

(Wednesday, October 29, 1947)

3:30 p.m. Discussion: J. D. McDonald, M.D., Evansville.

4:00 p.m. SPRAGUE GARDINER, M.D., Indianapolis.
Subject: *Sterility—Constitutional and Local Causes.*

4:30 p.m. Discussion: Maurice V. Kahler, M.D., Indianapolis.

5:00 p.m. Election of Section Officers.

Evening

6:30 p.m. Dinner meeting of Committee on Secretaries' Conference, Blue Room.

6:30 p.m. Loyola University Alumni dinner, Parlors A and B.

8:00 p.m. Bowling tournament for physicians, their wives and guests, French Lick Casino.

GENERAL SCIENTIFIC MEETING

(Main Convention Hall)

Thursday, October 30, 1947

Morning

9:30 a.m. DAN URSCHEL, M.D., Mentone.
Subject: *Brucellosis.*

10:00 a.m. WILLIAM S. MIDDLETON, M.D., Dean and Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin.
Subject: *Recent Advances in Therapy of Coronary Disease.*

10:30 a.m. ALEXANDER R. MacLEAN, M.D., Rochester, Minn.
Subject: *The Paradox: Psychoneurotic Malingering.*

11:00 a.m. GEORGE T. PACK, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York.
Subject: *Cancer of the Breast; Its Early Diagnosis and Treatment.*

11:30 a.m. Final meeting of the House of Delegates, west dining room. Annual election of officers and selection of convention city for 1948.
Meeting of Council immediately following adjournment of House of Delegates.

Noon

12:15 p.m. Luncheon meeting, Indiana Roentgen Society, Blue Room.
Speaker: GEORGE T. PACK, M.D., New York.

Afternoon

2:30 p.m. PHILIP LEWIN, M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School, Chicago.
Subject: *Treatment of Poliomyelitis in the Early Stages.*

3:00 p.m. LEE FOSHAY, M.D., Professor of Bacteriology, University of Cincinnati College of Medicine, Cincinnati.
Subject: *Use of Streptomycin in the Treatment of Tularemia.*

3:30 p.m. BRUCE K. WISEMAN, M.D., Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio.
Subject: *Modern Treatment of the Anemias.*

4:00 p.m. Adjournment, to visit exhibits.

* * *

ANNUAL DINNER
Thursday, October 30, 1947

Evening

6:30 p.m. Annual banquet, main dining room.
Presiding officer, FLOYD T. ROMBERGER, M.D., president, Indiana State Medical Association.
Presentation of certificate of merit to J. E. Ferrell, M.D., president 1946, by Floyd T. Romberger, M.D.
Speaker: ROSCOE L. SENSENICH, M.D., South Bend, president-elect of the American Medical Association.
Entertainment: TOM COLLINS, Kansas City, Mo.
Subject: *Price Tags on Progress.*



TOM COLLINS
Kansas City, Mo.



R. L. SENSENICH, M.D.
South Bend

(Motion picture projectors and lanterns supplied and operated through the courtesy of Leroy E. Burney, M.D., State Health Commissioner, and the Indiana State Board of Health.)

Women's Entertainment

Tuesday, October 28, 1947

9:00 a.m. Registration, mezzanine floor.

1:00 p.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Room 142, main floor.

7:00 p.m. Frolic in conjunction with Indiana State Medical Association, main dining room.

Wednesday, October 29, 1947

1:00 p.m. Luncheon, Woman's Auxiliary to the Indiana State Medical Association, Bamboo Room.

2:30 p.m. School of Instruction, Woman's Auxiliary.

1. Administrative Group, Room 142, main floor.
2. Public Relations Group, Room 143, main floor.
3. Organization group, Room F, basement. (For members-at-large and others interested in the formation of auxiliaries.)
4. Publications Group, Room G, basement.

Round table discussions following all sessions.

6:30 p.m. Dinner, Woman's Auxiliary, west dining room.

Greetings from FLOYD T. ROMBERGER, M.D., President, Indiana State Medical Association.

Speaker: T. M. OVERLEY, Indianapolis.

Subject: *Medical Quackery.*

Thursday, October 30, 1947

2:30 p.m. Party, North Porch, main floor.

6:30 p.m. Annual banquet in conjunction with the Indiana State Medical Association, main dining room.

Scientific Exhibit

J. L. Arbogast, M.D., Indianapolis, Chairman
James N. Collins, M.D., Indianapolis
Kenneth G. Kohlstaedt, M.D., Indianapolis

1. **Streptomycin in the Treatment of Tuberculosis.**
 Veterans Administration, Washington, D.C.
 Paul A. Bunn, M.D.
2. **Streptomycin: Experimental and Clinical Observations.**
 Mayo Clinic
 W. H. Feldman, M.D., and
 H. C. Hinshaw, M.D.
3. **Hypersplenism.**
 Ohio State University
 Bruce K. Wiseman, M.D.
4. **Heart Disease.**
 Caylor-Nickel Clinic
 Jack L. Eisaman, M.D.
5. **Cardiac Symptoms and Chronic Brucellosis.**
 Dan L. Urschel, M.D.
6. **Management of Tuberculosis.**
 Indiana Tuberculosis Association
7. **Tularemia—Prevalence.**
 Tularemia—Pathology.
 Atomic Energy
 Organization of the A.M.A.
 Medical Education and Hospitals.
 Mechanical Quackery.
 American Medical Association
8. **Industrial Health, Past, Present and Future.**
 Division of Industrial Hygiene
 Indiana State Board of Health
 Louis W. Spolyar, M.D.
9. **Plastic Surgery Repair.**
 Harold M. Trusler, M.D., and
 Thomas B. Bauer, M.D.
10. **Body Section Roentgenography.**
 Raymond C. Beeler, M.D.,
 James N. Collins, M.D., and
 William M. Loehr, M.D.
11. **Vitamin D Poisoning in Human Subjects.**
 Mayo Clinic
 Charles H. Slocumb, M.D., and
 Smith Freeman, M.D.
12. **Hospital Planning in Indiana.**
 Division of Health and Physical Education,
 Indiana State Board of Health
 Robert Yoho
13. **Tell Your Friends.**
 American Cancer Society
 Miss Ethel McLane, Indianapolis

ANNUAL CONFERENCE
INDIANA STATE BOARD OF HEALTH WITH LOCAL HEALTH OFFICERS

October 27 and 28, 1947

French Lick Springs Hotel, French Lick

MONDAY, OCTOBER 27

Morning:

10:00-12:00 Registration.

Afternoon:

1:15- 2:00 Committee Reports.
Presiding—Walter L. Portteus, M.D., President Indiana Health Officers' Association.

2:00- 5:00 Conference of State Board of Health with Local Health Officers.
Presiding—L. E. Burney, M.D., Secretary, Indiana State Board of Health.

2:00- 2:35 "New Legislation Concerning Local Health Departments"—D. C. Barrett, M.D., Director, Bureau of Local Health Administration.

2:35- 2:50 "Other Public Health Legislation"—George M. Brother, M.D., Director, Bureau of Preventive Medicine.

2:50- 3:30 "Hospital and Health Center Plans"—Martha O'Malley, M.D., Director, Division of Hospital and Institutional Services.

3:30- 4:00 "Functions of the Indiana Council on Mental Health"—Norman Beatty, M.D., Chairman, Indiana Council on Mental Health.

4:00- 1:30 "Progress in Tuberculosis Control"—Merle Bundy, M.D., Director, Division of Tuberculosis Control.

4:30- 4:45 "Services to Health Officers in Environmental Sanitation"—B. A. Poole, Director, Bureau of Environmental Sanitation.

4:45- 5:00 "Health Education Services Available to Health Officers"—Robert Yoho, Director, Bureau of Health Education, Records and Statistics.

Adjourn.

INDIANA HEALTH OFFICERS' ANNUAL BANQUET

French Lick Springs Hotel

MONDAY, OCTOBER 27

6:30 Presiding—Walter L. Portteus, M.D., President, Indiana Health Officers' Association.
Address—Harry S. Mustard, M.D., Director, School of Public Health, Columbia University.

All persons interested in Public Health are welcome.

TUESDAY, OCTOBER 28

Presiding—W. R. Taylor, M.D.

Morning:

9:30-10:00 Election of Officers.

10:00-12:00 General Business and Discussion of Committee Report.
Adjourn.

INDIANA STATE BOARD OF HEALTH BOARD MEMBERS

David R. Johns, M.D., Chairman
Howard Johnson, Vice-Chairman
Don E. Bloodgood, B.S.C.E., C.E.
Maynard K. Hine, D.D.S
Mary Heckard, R.N.
Glen L. Jenkins, Ph.D.
R. C. Julien, D.V.M.
Jacob T. Oliphant, M.D.
James L. Wyatt, M.D.
L. E. Burney, M.D., Secretary

INDIANA HEALTH OFFICERS' ASSOCIATION

W. L. Portteus, M.D., President
W. R. Taylor, M.D., Vice-President
J. W. Palmeier, M.D., Secretary
G. F. Kempf, M.D., Treasurer

Announcements

Conservation of Vision Committees Breakfast

Members of the State and County Conservation of Vision Committees are having a breakfast meeting in Parlors A and B, main floor, of the French Lick Springs Hotel, on Wednesday, October 29, 1947, at 7:30 A.M. Dr. Hedwig S. Kuhn, of Hammond, will be the speaker.

Industrial Health Committee Breakfast

The Committee on Industrial Health will hold a breakfast meeting in the Blue Room, French Lick Springs Hotel, at 8:00 A.M., on Wednesday, October 29, 1947.

Inaugural Frolic

The inaugural frolic for physicians, their wives, and guests, will be held in the main dining room, French Lick Springs Hotel, at 7:00 P.M., on Tuesday, October 28, 1947.

Anti-Tuberculosis Committees Luncheon

A luncheon meeting of members of State and County Anti-Tuberculosis Committees will be held in the Blue Room of the French Lick Springs Hotel, at 12:00 noon, on Wednesday, October 29, 1947. The Indiana Chapter of American College of Chest Physicians will participate, and the speakers will be Dr. Merle Bundy, of Indianapolis, and Mr. Murray A. Auerbach, of Indianapolis. There will be an x-ray conference, sponsored by the Indiana Chapter of American College of Chest Physicians.

Editorial Board Meeting

A meeting of the Editorial Board of THE JOURNAL of the Indiana State Medical Association will be held in Room 143, main floor, French Lick Springs Hotel, at 11:00 A. M., on Tuesday, October 28, 1947.

Instructional Courses

The Instructional Courses scheduled for this year's annual session of the Indiana State Medical Association, will be held at 11:00 A.M.; 1:00, 2:00, 3:00, and 4:00 P.M., on Tuesday, October 28, 1947, at the French Lick Springs Hotel.

1937 Class Reunion

A reunion of the 1937 class of Indiana University School of Medicine will be held at 12:00 noon, on Wednesday, October 29, 1947, in Parlor A.

Veterans Luncheon

A Veterans luncheon and meeting will be held in the west dining room at 12:30 P.M., on Wednesday, October 29, 1947.

Indiana Roentgen Society Luncheon

The Indiana Roentgen Society will hold a luncheon meeting at 12:15 P.M., in the Blue Room, on Thursday, October 30, 1947. The guest speaker will be George T. Pack, M.D., New York.

Secretaries' Conference Committee Dinner

The Committee on Secretaries' Conference will hold a dinner meeting in the Blue Room, at 6:30 P.M., on Wednesday, October 29, 1947.

Loyola University Alumni Dinner

The Loyola University alumni will meet at a dinner in Parlors A and B, at 6:30 P.M., on Wednesday, October 29, 1947.

General Practitioners Meeting

A meeting of General Practitioners will be held in the Main Convention Hall, at 8:00 P.M., on Wednesday, October 29, 1947, when Dr. Paul A. Davis, of Akron, Ohio, President of the American Academy of General Practice, will be the guest speaker.

ORDER YOUR TICKETS FOR THE 1947 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1947 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick Springs Hotel, French Lick, is now complete. All classes are on Tuesday, October 28, 1947.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now!

INSTRUCTIONAL COURSE SCHEDULE

Hours	*Parlor A Main Floor*	*Parlor B Main Floor*	*Game Room Mezzanine*	*Radio Room Mezzanine*	*North Porch Main Floor*
11:00 A.M.	The Treatment of the Infectious Diseases of Children Course 1	Genito-urinary Problems of the Elderly Course 6	Treatment of Fractures of the Forearm, Wrist, and Hand Course 11	Management of Colitis and Constipation Course 16	Diagnosis and Treatment of Common Skin Diseases Course 21
1:00 P.M.	Limitations in the Effectiveness of Chemotherapy and Antibiotics in Children's Diseases Course 2	New Techniques in Intravenous Feeding and Therapies Course 7	Backache Course 12	Office and Bedside Heart Examination Course 17	Diagnosis and Treatment of Common Gynecological Problems Course 22
2:00 P.M.	Infant Feeding Problems Course 3	Office Laboratory Tests for General Practice Course 8	Diagnosis and Treatment of Common Skin Diseases Course 13	Management of the Elderly Course 18	Management of Diabetes Mellitus Course 23
3:00 P.M.	Recognition, Diagnosis, and Treatment of Toxemias of Pregnancy Course 4	Minor Surgery for General Practice Course 9	Office Treatment of Anorectal Conditions Course 14	Psychological Management of Patients Course 19	Office and Bedside Heart Examination Course 24
4:00 P.M.	The Rh Factor Course 5	X-ray Demonstration of Chest Conditions Course 10	Office Surgery in Ear, Nose, and Throat Course 15	Diagnosis and Treatment of Eye Conditions in General Practice Course 20	Headache Course 25

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APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice....	No.:	No.:	No.:	No.:	No.:
Second choice.	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

Your tickets will be waiting for you at the Registration Desk, October 28, 1947.

Signed: M.D.

Address:

COMMITTEES FOR FRENCH LICK CONVENTION

EXECUTIVE COMMITTEE: Co-chairmen, Augustus P. Hauss, New Albany, Clarence E. Boyd, West Baden; John K. Spears, Paoli; William H. Garner, New Albany; W. E. Schoolfield, Orleans; E. P. Buckley, Jeffersonville; Samuel W. Baxter, New Albany; Herbert P. Sloan, New Albany; Mrs. James W. Baxter, Jr., New Albany.

RECEPTION COMMITTEE: Chairman, Percy R. Pierson, New Albany; H. L. Miller, West Baden; N. E. Keseric, French Lick; B. E. Sugarman, French Lick; Granville C. Colglazier, Leipsic; Ivan A. Clark, Paoli; Keith Hammond, Paoli; John K. Spears, Paoli; Schuyler F. Teaford, Paoli; William E. Schoolfield, Orleans; Philip T. Hodgin, Orleans; Carl E. Dillman, Corydon; H. H. Reeder, Jeffersonville; Parvin M. Davis, New Albany; E. W. Murphy, Lanesville; Joseph G. Dusard, Bedford; Marvin L. McClain, Scottsburg; L. W. Paynter, Salem; Novy E. Gobbel, English; Henry L. Worley, Henryville; G. A. Held, Jasper.

REGISTRATION COMMITTEE: Chairman, Clarence E. Boyd, West Baden; John M. Paris, New Albany; J. T. Carney, Jeffersonville; H. H. Deen, Leavenworth; F. P. Williams, Huntingburg; W. E. Amy, Corydon; John P. Scherschel, Bedford; J. P. Wilson, Scottsburg; I. E. Huckleberry, Salem.

VETERANS' AFFAIRS COMMITTEE: Chairman, William H. Garner, New Albany; Robert B. Smallwood, Bedford; Nathaniel C. Isler, Jeffersonville; James W. Baxter, Jr., New Albany; Frederick M. Applegate, Corydon.

INAUGURAL FROLIC COMMITTEE: Chairman, Ernest P. Buckley, Jeffersonville; Claude Dollens, Oolitic; Carl R. Bogardus, Austin; John M. Paris, New Albany; Augustus P. Hauss, New Albany; Mrs. James W. Baxter, Jr., New Albany.

GOLF TOURNAMENT COMMITTEE: Chairman, Herbert P. Sloan, New Albany; Samuel Adair, Jeffersonville; Arthur E. Newland, Bedford; John M. Paris, New Albany; Leo A. Salb, Jasper.

TRAPSHOOT COMMITTEE: Chairman, John K. Spears, Paoli; William E. Schoolfield, Orleans; H. K. Engleman, Georgetown; St. John Lukemeyer, Jasper; Waverly D. Bretz, Huntingburg.

BANQUET COMMITTEE: Chairman, Martin B. Strange, New Albany; George L. Regan, Sellersburg; J. Y. McCullough, New Albany; Samuel Baxter, New Albany; Wm. F. Edwards, New Albany; John K. Spears, Paoli.

BOWLING COMMITTEE: Chairman, Philip T. Hodgin, Orleans; John K. Spears, Paoli; Martin B. Strange, New Albany; Richard H. Woolery, Bedford.

FRATERNITY AND CLASS REUNION COMMITTEE: Chairman, Harry E. Voyles, New Albany; Howard Byrn, New Albany; William B. Strickland, Mitchell; Daniel H. Cannon, New Albany, Loniel H. Allen, Bedford.

HOUSING COMMITTEE: Chairman, Clarence E. Boyd, West Baden; Henderson L. Miller, West Baden; Keith Hammond, Paoli.

WOMEN PHYSICIANS: G. Irene Polhemus, New Albany.

WOMEN'S ENTERTAINMENT COMMITTEE: Chairman, Mrs. James W. Baxter, Jr., New Albany; Mrs. Clarence E. Boyd, West Baden; Mrs. A. P. Hauss, New Albany; Mrs. John K. Spears, Paoli; Mrs. Wm. H. Garner, New Albany; Mrs. E. P. Buckley, Jeffersonville; Mrs. W. E. Schoolfield, Orleans; Mrs. S. M. Baxter, New Albany; Mrs. Herbert P. Sloan, New Albany; Mrs. Martin B. Strange, New Albany.

WOMAN'S AUXILIARY CONVENTION COMMITTEES:

COMMITTEE ON CONVENTION ARRANGEMENTS: Chairman, Mrs. James W. Baxter, Jr., New Albany; Mrs. A. P. Hauss, New Albany; Mrs. John K. Spears, Paoli; Mrs. Wm. H. Garner, New Albany; Mrs. E. P. Buckley, Jeffersonville; Mrs. W. E. Schoolfield, Orleans; Mrs. S. M. Baxter, New Albany; Mrs. Herbert P. Sloan, New Albany; Mrs. Clarence E. Boyd, West Baden; Mrs. Martin Strange, New Albany.

COMMITTEE ON BOWLING: Chairman, Mrs. John P. Gentile, New Albany; Mrs. Wm. H. Garner, New Albany.

COMMITTEE ON DOCTORS, THEN AND NOW: Chairman, Mrs. S. M. Baxter, New Albany; Mrs. Herbert P. Sloan, New Albany; Mrs. Percy Pierson, New Albany; Mrs. W. F. Edwards, New Albany; Mrs. E. P. Buckley, Jeffersonville.

COMMITTEE ON AFTERNOON PARTY THURSDAY, OCTOBER 30, 2:30 P. M.: Chairman, Mrs. Harry E. Voyles, New Albany; Mrs. A. M. Baker, New Albany; Mrs. C. E. Boyd, West Baden; Mrs. Sam Adair, Jeffersonville; Mrs. D. L. Carlberg, Jeffersonville.

BING CROSBY is reported to be buying a stock farm near French Lick. The Orange County boys immediately sent him an invitation to come on and meet his neighbors at the Indiana State Medical Association Convention.

MEDICAL MEN OF NATIONAL NOTE are coming from coast to coast to talk to you at French Lick. Will you be there to hear them?

IT IS NOT NECESSARY for you to reserve a de luxe suite in the main hotel while attending the convention. The committee has listed several smaller hotels and modern tourist homes in the French Lick-West Baden area, all conveniently located near the main convention hall.

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at French Lick, October 28, 29, and 30, 1947.

The House of Delegates will be constituted as follows: Marion County, seventeen delegates; Lake County, five delegates; Allen County, four delegates; St. Joseph County, three delegates; Vanderburgh County, three delegates; Daviess-Martin, Dearborn-Ohio, Delaware-Blackford, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo, and Wayne-Union County societies, each two delegates; the other sixty-four county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, William R. Davidson, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, A. B. Graham, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, E. M. VanBuskirk, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl M. McCaskey, J. T. Oliphant, N. K. Forster, and J. E. Ferrell; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Ray E. Smith, 1021 Hume Mansur Building, Indianapolis 4, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 4:00 P.M., Tuesday, October 28, in the main convention hall of the French Lick Springs Hotel, French Lick, and again at 11:30 A.M., Thursday, October 30, in the west dining room of the French Lick Springs Hotel. (Luncheon meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the Council.
8. Reports of standing and special committees:
 - (1) Credentials.
 - (2) Executive Committee.
 - (3) Arrangements.
 - (4) Scientific Work.
 - (5) Instructional Courses.
 - (6) Public Policy and Legislation.
 - (7) Bureau of Publicity.
 - (8) Civic and Industrial Relations.
 - (9) Medical Education and Hospitals.
 - (10) Public Relations.
 - (11) Journal Publication.
 - (12) Secretaries' Conference.
 - (13) Scientific Exhibit.
 - (14) Necrology and History.
 - (15) Mental Health.
 - (16) Maternal and Child Health.
 - (17) Liaison Committee of the Division of Services for Crippled Children.
 - (18) Auditing.
 - (19) Control of Cancer.
 - (20) Venereal Disease.
 - (21) Industrial Health.
 - (22) Indiana Inter-Professional Health Council.
 - (23) Anti-Tuberculosis.
 - (24) Conservation of Vision.
 - (25) Medical Relief.
 - (26) Rural Medical Care.
 - (27) Hard of Hearing.
 - (28) Rehabilitation Services.
 - (29) Medical and Nursing School Scholarships.
 - (30) Centennial Celebration.
 - (31) Veterans Committee.
 - (32) State Fair.
 - (33) Study of Undergraduate Medical Education.
9. Reading of communications.
10. Reading of memorials and resolutions.
11. Unfinished business.
12. New business.
13. Adjournment.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1947, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Don F. Cameron, Fort Wayne, and F. S. Crockett, LaFayette; and alternates, Norman M. Beatty, Indianapolis, and A. M. Mitchell, Terre Haute.

Delegates from the first, fourth, seventh, tenth, and thirteenth districts are reminded that the terms of their councilors will expire December 31, 1947, and new councilors should be elected to succeed the following:

First District: I. C. Barclay, Evansville.

Fourth District: Charles F. Overpeck, Greensburg.

Seventh District: Cyrus J. Clark, Indianapolis.

Tenth District: William H. Howard, Hammond.

Thirteenth District: Alfred Ellison, South Bend.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

RAY E. SMITH,
Executive Secretary.

Reports of Officers and Committees

EXECUTIVE SECRETARY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The good ship "Indiana Medicine" has sailed successfully upon the Organization Sea during the past year. Inside the pilot house, with his hands firmly upon the steering wheel, has been the president of the state medical association. "S.S. Indiana Medicine" has avoided all rocks, reefs, and sandbars, and ridden out all storms and gales.

The executive secretary has labored in the ship's engine room, with oil can in hand, trying to keep the machinery well oiled and humming smoothly. Occasionally he has had to grab a shovel and stoke the furnaces to keep up the steam, but being seasoned mariners, the captain and his crew held true to the course and brought "Indiana Medicine" safely into port on schedule.

The foregoing allegory represents your executive secretary's conception of his duties in relation to those of the officers of the association. The president, councilors, and executive committee members may be compared to the captain and crew of a ship. It is they who chart the course of the association by determining its policies. It is the duty of the executive secretary to carry out their orders . . . to keep the organization wheels spinning.

Since the 1946 report, the executive secretary has attended all district meetings in the state except two, missing the Second and Seventh district meetings because of attendance at sessions of the A.M.A. House of Delegates. He has represented the association at numerous meetings of allied groups, and has addressed four Woman's Auxiliary units. Out-of-state meetings attended include: Annual session of Michigan State Medical Society, Detroit; supplementary session of the A.M.A. House of Delegates, Chicago; Editors' and Secretaries' Conference of A.M.A., Chicago; Conference on Rural Medical Services, Chicago; National Conference on Medical Services, Chicago; centennial session of the American Medical Association, Atlantic City, and Conference on Cooperation of the Physician in the School Health and Physical Education program, Highland Park, Illinois.

Throughout the year the writer has assisted the various committees of the association with their work, wherever opportunity presented itself. This being a legislative year, the Committee on Public Policy and Legislation required virtually the entire time of the executive secretary during the sixty-one days the Indiana General Assembly was in session. The work of this committee is covered in its report, but the undersigned was happy to take part in its program for good health legislation.

The headquarters office has endeavored to operate efficiently and economically. Your executive secretary, on behalf of the headquarters staff and himself, wishes to thank the physicians for their co-operation, always generously given, and to pledge the continued devotion of all employees in working for the best interest of the association.

May the good ship "Indiana Medicine" have as successful a voyage in 1947-48 as it did in 1946-47!

RAY E. SMITH,
Executive Secretary.

TREASURER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The accompanying report prepared by certified public accountants gives our financial statement for the period ending December 31, 1946. On page 1034 will be found the report of the Auditing Committee, which met July 16, 1947.

While our records show considerable gain in income during the current year, we also have incurred considerable expense for scholarships, which is discussed in the report of the Committee on Medical and Nursing School Scholarships.

The following report has been prepared by George S. Olive and Company of Indianapolis:

January 8, 1947.

The Council,
Indiana State Medical Asociation,
Indianapolis, Indiana.

Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1946. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1946; and, (3) statements of receipts and disbursements of all funds, year ended December 31, 1946. A list of the statements is presented on the first page following this text.

General Comment

In exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1946, showing in summary form the sources from which this increase was derived.

The increase of $4,744.46 results principally from an excess of operating cash receipts over operating cash disbursements of the general fund. Increases in the general fund are due mainly to additional income from membership dues and from exhibit rents, offset by increase in headquarters office expense and annual session expense. A complete analysis of these increases and decreases is presented in exhibit C.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1946, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the general fund, of THE JOURNAL of The Indiana State Medical Association, and of the Medical Defense fund are presented in exhibits C, D, and E.

Yours very truly,
GEO. S. OLIVE & CO.
Certified Public Accountants.

INDIANA STATE MEDICAL ASSOCIATION
List of Statements Contained in Report on Examination of Cash Records, Year Ended December 31, 1946

Exhibit A—Analysis of increase in assets, all funds, year ended December 31, 1946

Exhibit B—Statement of assets, all funds, at December 31, 1946

Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1946, and December 31, 1945

Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1946

Exhibit E—Statement of cash receipts and disbursements of the Medical Defense fund, year ended December 31, 1946

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds
Year Ended December 31, 1946

TOTAL ASSETS, DECEMBER 31, 1946—Exhibit B		$56,542.39
TOTAL ASSETS, DECEMBER 31, 1945		51,797.93
NET INCREASE		$ 4,744.46
Arising from the following sources:		
Excess of operating cash receipts over operating cash disbursements, general fund, year ended December 31, 1946:		
Receipts—Exhibit C	$46,630.70	
Disbursements—Exhibit C	42,046.37	
		$4,584.33
Excess of operating cash receipts over operating cash disbursements, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1946:		
Receipts—Exhibit D	37,941.01	
Disbursements—Exhibit D	37,558.88	
		382.13
Excess of operating cash disbursements over operating cash receipts, Medical Defense Fund, year ended December 31, 1946:		
Receipts—Exhibit E	2,865.50	
Disbursements—Exhibit D	37,558.88	
		(222.00)
TOTAL NET INCREASE		$4,744.46

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Statement of Assets, All Funds, at December 31, 1946

GENERAL FUND:			
Cash on deposit—Exhibit C		$5,613.25	
Petty cash fund		200.00	
Investments:			
Marion County Flood Prevention bonds	$3,000.00		
Indianapolis City Hospital bonds	5,000.00		
U. S. Treasury bonds	13,000.00		
U. S. Savings bonds	5,000.00		
		26,000.00	
Total General Fund			$31,813.25
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			6,445.42
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		3,283.72	
Investments:			
Marion County Flood Prevention bonds	2,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	5,000.00		
U. S. Baby bonds	3,000.00		
		15,000.00	
Total Medical Defense Fund			18,283.72
TOTAL ASSETS, ALL FUNDS—Exhibit A			$56,542.39

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION
Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1946, and December 31, 1945

	Year Ended Dec. 31, 1946	Dec. 31, 1945	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$1,028.92	$465.91	$563.01

RECEIPTS:			
Membership dues	35,776.00	33,603.00	2,173.00
Income from exhibits	9,926.00	5,695.00	4,231.00
Interest income:			
U. S. Treasury bonds	290.65	368.75	(78.10)
U. S. Savings bonds	125.00	125.00	
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	
Marion County, Indiana, Flood Prevention bonds	127.50	127.50	
Refund on convention expense		69.56	(69.56)
Petty cash refund—contra		500.00	(500.00)
Reimbursements from American Medical Association	72.41	194.15	(121.74)
Check for Dunninger fee		1,250.00	(1,250.00)
Travel refunds	113.14		(113.14)
Miscellaneous income		56.02	(56.02)
	46,630.70	42,188.98	4,441.72
BEGINNING BALANCE PLUS CASH RECEIPTS	47,659.62	42,654.89	5,004.73
DISBURSEMENTS:			
Transfer of applicable portion of dues to THE JOURNAL of The Indiana State Medical Association—Exhibit D	6,980.00	6,726.00	254.00
Medical Defense fund—Exhibit E	2,515.50	2,439.00	76.50
Headquarters office expense	13,499.43	11,384.80	2,114.63
Publicity committee	1,834.98	2,476.37	(641.39)
Public policy	325.99	1,403.74	(1,077.75)
Council	6,702.41	6,267.24	435.17
Officers	474.05	496.75	(22.70)
Annual session	6,700.03	4,750.98	1,949.05
Miscellaneous committees	1,756.31	2,353.95	(597.64)
Federal old age benefit tax	85.65	93.39	(7.74)
Instructional course expense	15.63		15.63
Refunds of dues	372.00	36.75	335.25
Petty cash refunds—contra		500.00	(500.00)
National Conference on Medical Service	585.98	147.59	438.39
Miscellaneous expense		15.26	(15.26)
Payment for American Medical Association	72.41	194.15	(121.74)
Funds transferred to Medical Defense fund		2,000.00	(2,000.00)
Refunds on exhibit rent	126.00	340.00	(214.00)
	42,046.37	41,625.97	420.40
CASH BALANCE AT END OF YEAR	$5,613.25	$1,028.92	$4,584.33

EXHIBIT D

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements
Year Ended December 31, 1946

The Journal of The Indiana State Medical Association

BALANCE, JANUARY 1, 1946		$6,063.29
RECEIPTS:		
Subscriptions—members—Exhibit C	$6,980.00	
Subscriptions—non-members	394.42	
Advertising	30,410.93	
Collection on accounts receivable	66.05	
Single copy sales	40.50	
Electrotypes	49.11	
Total Receipts—Exhibit A		$37,941.01
		44,004.30
DISBURSEMENTS:		
Salaries	12,156.73	
Printing	21,283.49	
Office postage	352.01	
Journal postage	603.35	
Advertising commisions	422.40	
Electrotypes	699.19	
Reporting	125.50	
Press clippings	65.85	
Editor and editorial board expense	91.76	
Office supplies	773.82	
Rent	440.00	
Electricity	41.59	
Telephone and telegraph	239.17	
Federal old age benefit tax	87.71	
Miscellaneous	176.31	
Total disbursements—Exhibit A		37,558.88
BALANCE, DECEMBER 31, 1946—Exhibit B		$6,445.42

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1946

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1946		$3,505.72
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—Exhibit C	$2,515.50	
Interest income:		
U. S. Treasury bonds	140.00	
U. S. Savings bonds	125.00	
Marion County Flood Prevention bonds	85.00	
Total Receipts—Exhibit A		2,865.50
		6,371.22
DISBURSEMENTS:		
Malpractice fees	1,250.00	
Attorney fees	1,800.00	
Treasurer's bond	37.50	
Total disbursements—Exhibit A		3,087.50
BALANCE, DECEMBER 31, 1946—Exhibit B		$3,283.72

A. F. WEYERBACHER, M.D.,
Treasurer.

CHAIRMAN OF THE COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Meeting twice during the 1946 annual session and three times since, the Council has transacted a large volume of business. While the minutes of all these meetings have appeared in THE JOURNAL, a review of the proceedings reveals six actions of paramount importance. They are:

1. Increasing length of the annual session by one day and adding instructional courses to a French Lick meeting for the first time.
2. Establishment of six $500-a-year scholarships for medical school students who will agree to practice for five years in a community needing a doctor.
3. Awarding of six $200-a-year scholarships to girls needing funds to study nursing.
4. Recognizing physicians who have practiced fifty years or more by presenting them with lapel buttons and certificates of distinction.
5. Presenting medals to the three senior medical school students with the highest grades.
6. Formation of a committee to study undergraduate medical education and make definite recommendations to the House of Delegates.

Attendance at the meetings has been most gratifying. The councilors have approached all problems with an earnest seriousness, and their decisions have been made only after thoughtful consideration.

A brief resumé of the Council actions follows:

First Meeting, Indianapolis, October 29, 1946

Recommendation for increasing state dues from $10.00 to $15.00 sent to House of Delegates.

Medical Relief Committee designated as liaison committee with State Department of Public Welfare.

Re-elected Dr. E. M. Shanklin as editor of THE JOURNAL for the fifteenth time.

Dr. Lall Montgomery, of Muncie, and Dr. Pierce MacKenzie, of Evansville, were elected to the Editorial Board.

Second Meeting, Indianapolis, October 31, 1946

President's badges voted for all past presidents of the association who had not previously received one.

Midwinter Meeting, Indianapolis. January 12, 1947

Treasurer's report revealed total assets of the association on December 31, 1946 were $56,542.39.

Fixed October 28, 29, and 30, 1947, as dates for 1947 annual session at French Lick.

Appropriated $3,000 for the Committee on Convention Arrangements.

Created six medical school scholarships, each for $500 per year, for students who needed financial help and would agree to practice for at least five years in a community needing medical services.

Dr. Alfred Ellison was elected chairman of the Council, succeeding Dr. A. M. Mitchell.

Dr. Carl H. McCaskey was re-elected to the Executive Committee and Dr. Walter L. Portteus was elected to the Executive Committee to succeed Dr. Cleon A. Nafe, president-elect.

Spring Meeting, Indianapolis, April 13, 1947

"Home Town" medical care fee schedule between Veterans Administration and association approved.

Program for 1947 annual session was approved.

Dr. Kenneth G. Kohlstaedt, Dr. O. O. Alexander, and Dr. J. T. Oliphant nominated for the Editorial Board.

Dr. N. K. Forster elected alternate delegate to the House of Delegates of the American Medical Association to succeed Dr. George Collett, who resigned.

Summer Meeting, Indianapolis, July 20, 1947

Committee appointed to study undergraduate medical school education and make definite recommendations to the House of Delegates.

Doctors who have been in practice fifty years or more are to be honored by presenting them with lapel buttons (for men) or clasp pins (for women) and certificates of distinction at annual dinner.

Three-point cancer program proposed by the State Board of Health, as follows, approved:

(1) Education of the laity.
(2) Education of the medical profession in new developments in cancer diagnosis and treatment.
(3) Establishment of a cancer registry.

Approval given State Board of Health's hospital and health center construction program.

Headquarters office directed to procure list of specialists from each county medical society on behalf of the Council for submission to Veterans Administration.

Six scholarships of $200 each voted for girls needing funds to enroll in any of the twenty-seven accredited nursing schools of the state.

Three highest students in graduating class of the Indiana University School of Medicine to be presented scholarship medals.

Gave approval to establishment of Bureau of Information in Department of Public Health, Indiana University School of Medicine, under Dr. Thurman B. Rice.

A number of individuals appeared before the Council and many committee reports were received, all of which are not mentioned in this brief outline because they are in the published minutes.

I would be remiss in my duty if I did not pay tribute to Dr. A. M. Mitchell, the former chairman, for his excellency in presiding over the Council meetings. The Council is proud of the fact that the American Medical Association recognized his organization ability and made him chairman of its 1947 Conference of County Medical Society Officers, held at Atlantic City last June 8.

ALFRED ELLISON, M.D., *Chairman.*

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

The First District Medical Society meeting was held at the Princeton Country Club on May 22, 1947. The following officers were elected: president, Dr. George W. Willison, Evansville; vice-president, Dr. Virgil McCarty, Princeton; secretary-treasurer, Dr. Willard Barnhart, Evansville; councilor, Dr. Herman Combs, Evansville.

Dr. Cleon A. Nafe, president-elect of the Indiana State Medical Association; Mr. Ray E. Smith, executive secretary of the Indiana State Medical Association; and Dr. I. C. Barclay, councilor of the First District, were speakers at the dinner.

The scientific program was given by faculty members of the Indiana University School of Medicine as follows: "Poliomyelitis," by Dr. Lyman T. Meiks; "Treatment of Suppurative Lesion of the Chest," by Dr. J. Stanley Battersby; "Myasthenia Gravis," by Dr. Joseph E. Tether; and "Common Lesions of the Cervix," by Dr. Carl P. Huber.

I. C. Barclay, M.D., *Councilor.*

SECOND COUNCILOR DISTRICT

The attendance and interest in the County Societies of the District was increased during the past year.

On June 12, 1947, the Greene County Medical Society entertained the District Society at the Linton Country Club, and one of the most interesting and instructive meetings was held. The meeting was attended by sixty members from the District. Following a splendid dinner as guests of the Greene County Medical Society, an unusual program followed. Dr. G. D. Scott of Sullivan gave a talk and showed color films of fractures of the hip. He also presented a film on nephrectomy. Dr. Paul Fouts of Indianapolis gave a talk on "Diagnosis and Diseases of the Blood." Dr. Sprague Gardiner of Indianapolis presented a paper on "Treatment and Symptoms of the Menopause."

Officers elected for the coming year were: Dr. W. C. Reed, Bloomington, president; Dr. J. S. Brown, Carlisle, secretary; Dr. J. H. Crowder, Sullivan, Councilor. The next meeting will be held at Bloomington.

J. H. Crowder, M.D., *Councilor.*

THIRD COUNCILOR DISTRICT

The Third District is on the march. The district society membership of 137 is probably the largest in history. Plans for at least four new county hospitals are under way and two of these will probably start construction before the next annual councilor report. There is an improved distribution of medical care due to the location of some new doctors in several counties in the district. The county societies are alert and most of them are holding regularly scheduled meetings.

The first bi-county Public Health Department in Indiana is now established in Floyd and Harrison counties. Dr. W. E. Amy, Corydon, has accepted the position of full-time health director for the two counties, and the headquarters is in New Albany.

The annual meeting of the Third District Medical Society was held at Silvercrest, Southern Indiana Tuberculosis Hospital, New Albany. Welcome addresses by Dr. Parvin Davis, president of the Floyd County Medical Society, and Dr. J. V. Pace, superintendent of Silvercrest, were made during the luncheon.

Drs. Percy R. Pierson, district president, and William F. Edwards, district secretary, officiated at the scientific and business meetings. Dr. K. Armand Fischer, of the University of Louisville, presented a very excellent paper on "Low Back Pain, Its Diagnosis and Treatment," which was followed by a round-table discussion.

State association president, Dr. Floyd T. Romberger, Lafayette, drove approximately two hundred miles to attend this meeting, and very ably presented a review of the problems and developments of medical organization in Indiana. Thank you, Dr. Romberger.

Mr. Ray E. Smith, State Executive Secretary, discussed the medical registration law and the 1947 meeting at French Lick, and again demonstrated that he is on the job and knows the answers.

Yours truly presented the Councilor's report on the state of the district.

Dr. Keith Hammond, Paoli, was elected president of the district society for 1948, and Dr. B. E. Sugarman, French Lick, was elected secretary-treasurer. French Lick was selected for the 1948 meeting place.

This year the Third District Medical Society has the honor of being host to the 98th annual session of the Indiana State Medical Association at French Lick Springs Hotel, in Orange County. This will be the greatest scientific program in the history of the association; three full days of scientific meetings, and instructional courses, augmented by an exceptional program of entertainment.

The Orange County and Third District Medical Societies will be looking for you at French Lick, October 28, 29 and 30.

Augustus P. Hauss, M.D., *Councilor.*

FOURTH COUNCILOR DISTRICT

The Fourth District of the Indiana State Medical Association held its annual meeting at Seymour, May 14, 1947. Dr. L. N. Osterman presided at the meeting.

At the meeting of the House of Delegates, Batesville was selected as the next meeting place.

The following officers for 1948 were elected:

President, Dr. George Row, Osgood.

Vice-President, Dr. Charles Manley, Rising Sun.

Secretary-Treasurer, Dr. S. W. Hisrich, Batesville.

Councilor for 3 years, Dr. O. A. Turner, Madison.

Dr. Floyd T. Romberger, president, Indiana State Medical Association, and Mr. Ray Smith, executive secretary, were as refreshing as the good food served at the evening banquet.

CHARLES F. OVERPECK, M.D., *Councilor.*

FIFTH COUNCILOR DISTRICT

All the county societies in the Fifth District Medical Society are functioning and hold regular meetings. There has been an increase in membership in the district.

The Fifth District Medical Society met in Terre Haute on May 2 for their annual meeting. This was held in conjunction with the Terre Haute Academy of Medicine. The following addressed the society:

Cleon Nafe, president-elect of the Indiana State Medical Association, spoke on Medical Organization.

Ray E. Smith, executive secretary of the Indiana State Medical Association.

Dr. Tinsley Harrison, of Dallas, Texas, spoke on Coronary Disease.

Dr. Peter Rosi of Chicago spoke on Cancer of the Colon and Rectum.

Thomas Hendricks, secretary of the Council on Medical Service of the American Medical Association, spoke on Medical Services throughout the United States, and the Admiral Boone Report on Coal Mines.

Dr. Dick Steele of Greencastle was elected president of the Fifth District Medical Society.

Dr. Robert K. Webster of Brazil was elected vice-president.

Dr. M. C. Topping of Terre Haute was elected secretary.

The next annual meeting of the Fifth District Medical Society will be held in Greencastle.

A. M. MITCHELL, M.D., *Councilor.*

SIXTH COUNCILOR DISTRICT

The Sixth District is in excellent social, professional, and economic condition. Harmony and good feeling exist throughout the District. The annual District meeting was noteworthy for its interesting and useful program. The membership is in hearty accord with the attitude of President Romberger, who, in a masterly speech, at Richmond, laid stress on the importance of wholehearted support of the State and County programs.

The proposed hospitals in Rush County and in Hancock County are held up by excessive building costs, and since they are being built solely by local funds, their action is understandable. They might get buildings earlier by Federal aid, but they happen to be of the stock who prefer doing for themselves and remaining independent.

A noteworthy and unique incident occurred at Mooreland in Henry County where a small but prosperous community organized a committee who looked for and secured a capable physician and gave a public dinner to introduce him. The county profession came, nearly 100 per cent, to join with the community. The incident demonstrated that much of the so-called maldistribution of doctors can be corrected by community effort, instead of wailing. We think the reception and greeting was the first of its kind in Indiana.

W. U. KENNEDY, M.D., *Councilor.*

SEVENTH COUNCILOR DISTRICT

The Seventh District meeting will be held at Martinsville on Tuesday, December 9. The program will provide interesting clinical and scientific discussions, with a prominent out-of-state essayist, whose name will be announced later, for the evening meeting. It is hoped that a round table, with an out-of-state speaker, can be arranged for the afternoon program.

Affairs in the district have run smoothly during the year.

C. J. CLARK, M.D., *Councilor.*

EIGHTH COUNCILOR DISTRICT

The county societies of the Eighth District have continued regular meetings during the last year. There is noticed an increase of interest in the problems of medicine since the members who had been in military service have resumed their activities as civilian practitioners.

Our annual meeting was held at Portland, June 25, 1947. The Jay County Society provided an excellent afternoon and evening meeting of entertainment and scientific instruction. A good dinner was served at the country club.

It was the action of the district society that postgraduate courses be recommended and that they be held in one of the larger cities of the district.

President, Dr. Romberger, and secretary, Ray Smith, reported on activities of the state organization.

Dr. Frank Teague of Indianapolis delivered a scientific discussion entitled, "Low Back Pain."

The officers elected for the coming year were Dr. Fred Wishard, as president, and Dr. M. A. Austin, secretary. The meeting for 1948 will be held in Anderson.

E. H. CLAUSER, M.D., *Councilor.*

NINTH COUNCILOR DISTRICT

It is gratifying to report that all component societies of the Ninth District Medical Society

have been functioning with renewed vigor during the past year.

The annual meeting of the Society was held at Mudlavia Springs Hotel, near Attica, on May 15, 1947. Dr. Lee J. Maris of Attica presided at the meeting and deserves much credit for the splendid meeting. In the morning many of the members and their wives enjoyed golf at the Harrison Hills Country Club. An excellent scientific program was arranged for the afternoon. Dr. Lowell T. Coggeshall, an alumnus of Indiana University, and now Chairman of the Department of Medicine at Chicago University, gave the principal address, "Current Status of Influential Vaccines."

Excellent papers were read by Dr. Stuart R. Combs, of Terre Haute, on "The Cardiac as a Surgical Risk," and by Dr. Frank W. Peyton, of Lafayette, on "Sterility".

Speakers at the banquet were Dr. Floyd T. Romberger, of Lafayette, president of the Indiana State Medical Association, and Mr. Ray E. Smith, of Indianapolis, executive secretary of the Indiana State Medical Association.

The 1948 meeting is to be held at Frankfort and the officers of the host society are to serve as officers for the district during 1948.

WEMPLE DODDS, M.D., *Councilor.*

TENTH COUNCILOR DISTRICT

The Tenth District Medical Society of the Indiana State Medical Association, led by Dr. G. M. Cook, president, and Dr. A. C. Remich, secretary, both of Hammond, held its spring meeting at Teibel's Restaurant in Schererville, on April 10, 1947. Guest speakers were Dr. Floyd T. Romberger, president, Indiana State Medical Assocation, and Mr. Ray Smith, executive secretary. Dr. Romberger outlined the work of the state association and appealed for the loyal support of all physicians in making the association strong and effective. He particularly emphasized the duties of the various committees and appealed for sincere effort and cooperation in making their work effective.

Mr. Smith outlined the work of the association relative to legislation in the last General Assembly and praised the effectiveness of the legislative committee of the state association, and paid special tribute to the Lake County Medical Society for its very effective contribution to the defeat of the chiropractic bill.

The Tenth District Medical Society met with the Indiana Board of General Practice of Medicine at Gary on September 17, 1947. The program included a trip through the plant of the Carnegie Illinois Steel Corporation and papers on industrial medicine by Drs. David R. Johns, S. J. Petronella, A. C. Remich, J. C. Donchess, A. V. Cole, E. H. Carleton, E. S. Jones, and T. J. Smith. At a dinner in Hotel Gary that evening, Dr Julius E. Lips of New York City spoke on "The Practice of Medicine Among Primitive People."

Officers elected for 1947-48 are: Dr. Neal Davis, Lowell, president; Dr. Frank G. Sink, Remington, secretary; Dr. William H. Howard, Hammond, re-elected councilor.

WILLIAM H. HOWARD, M.D., *Councilor.*

ELEVENTH COUNCILOR DISTRICT

The Eleventh Councilor District Medical Association continues to hold two meetings each year, one in the spring and one in the fall.

The spring meeting was held in Hotel La Fontaine, Huntington, May 21. This was an outstanding program and was put on by the Huntington County Medical Society. Dr. Willis D. Gatch, of the Indiana School of Medicine, presented in his usual good form the subject, "Peripheral Circulation; Its Derangements and Their Treatment." Dr. Paul J. Fouts, also of the Indiana School of Medicine, presented the subject, "Diagnosis of Diseases of the Blood; Laboratory Aids." Both papers were well received and provoked considerable discussion.

Officers elected at the Huntington meeting for 1947-48; Dr. S. D. Malouf, Peru, president, and Dr. O. G. Brubaker, North Manchester, re-elected secretary-treasurer.

A fine dinner was served in the evening to ninety members and guests. The after-dinner speaker was Mr. Ned Gorrell, of Winamac, who used as his subject, "Homespun Philosophy," and he is really a good speaker.

We were happy to have as special guests state president Dr. Romberger, of Lafayette, and executive secretary Ray Smith, of Indianapolis. Both made short talks at the afternoon and evening sessions.

Our fall meeting was held in Wabash, September 17. At this meeting Dr. Dan Urschel, of Mentone, discussed "Brucellosis," and Dr. Philip Thorek, of Chicago, discussed the "Acute Abdomen." The Wabash County Medical Society was host for this meeting.

We have a membership of 198. This includes honorary members and a few who are still in service.

The Eleventh District is in good working condition, with each of the seven county societies functioning in good form.

C. S. BLACK, M.D., *Councilor.*

TWELFTH COUNCILOR DISTRICT

The Twelfth District is in good shape and all component Societies are functioning very well.

The District Meeting was held in Fort Wayne, May 6, 1947. The scientific program was provided by three members of the faculty of the University of Cincinnati College of Medicine. The speakers and their subjects were: Dr. Richard Bryant, "Toxemia of Pregnancy"; Dr. Edward McGrath, "Diagnosis and Management of Lung Tumors";

and Dr. A. Ashley Weech, "The Emotional Needs of the Child in the Development of Behavior."

Dr. Floyd T. Romberger gave a report on the activities of the State Association, and Mr. Ray E. Smith also gave a brief report.

The officers elected for the next year are: Dr. G. T. Bowers, Fort Wayne, president; Dr. J. R. Nash, Albion, vice-president, and Dr. K. M. Beierlein, Fort Wayne, secretary-treasurer.

PAUL A. GARBER, M.D., *Councilor.*

THIRTEENTH COUNCILOR DISTRICT

During the past year the profession of Kosciusko County became actively organized again and are conducting regular meetings.

The District meeting will be held in South Bend on November 12. A cordial invitation is extended to all members of the state association to join with us in making this an outstanding meeting. It is our hope to have an excellent program, presented by some physicians of national prominence.

ALFRED ELLISON, M.D., *Councilor.*

COMMITTEE ON CREDENTIALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Credentials served in its official capacity twice during the past year, that is, at the regular meetings of the House of Delegates which were held on October 29 and 31, 1946, during the annual session at Indianapolis.

The Constitution and By-Laws of the Indiana State Medical Association state that each county medical society must certify its delegates and alternates previous to the annual session. A postal card notification, signed by the secretary of the local county medical society and sent to the headquarters office, is sufficient certification. If you have not yet taken this action in your society, we urge that this be done immediately.

W. E. AMY, M.D., *Chairman,*
HUGH S. RAMSEY, M.D.,
PARVIN M. DAVIS, M.D.,
T. A. DYKHUISZEN, M.D.,
GEORGE N. LOVE, M.D.

EXECUTIVE COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Executive Committee, whose duty it is under the by-laws to "plan and execute such work as may be necessary for the welfare of the association and the conduct of the executive secretary's office," met eight times during the past year and tried conscientiously to fulfill this obligation. In reaching its decisions, the committee constantly kept in mind the "welfare of the association."

In addition to a multitude of routine matters handled by the committee in the past twelve months, it has put into effect, and has carried out, policies determined by the Council. This was done in line with the by-laws, which state that "it (Executive Committee) shall represent the Council during intervals between meetings of that body."

Composed of the president of the association, the president-elect, the chairman of the Council and two physicians elected by the Council, the Executive Committee is, by nature of its work and composition of its membership, closer to the modus operandi of the association than any other committee. The committee, therefore, knows whereof it speaks in declaring that the medical association is in the best financial condition of its history and in a sound position from the standpoint of intra- and inter-activities.

A more-than-normal change took place this year in the personnel of the committee. It was with keen regret that we accepted the resignation of our chairman, who had served so faithfully in this capacity for eleven years, which was due to his elevation to the position of president-elect. The committee will have the benefit of his judgment until he completes his term as president. Dr. Carl H. McCaskey succeeded Dr. Cleon A. Nafe as chairman, and Dr. Walter L. Portteus of Franklin was elected a member of the committee by the Council to replace Doctor Nafe. A change in the chairmanship of the Council automatically placed Dr. Alfred Ellison of South Bend on the Executive Committee.

The association president, Doctor Romberger, has attended every meeting, giving the executive committee the benefit of his sound judgment, and lending his full support to its activities.

Mutual Medical Insurance, Inc.

By the time the House of Delegates meets at French Lick, Mutual Medical Insurance, Inc., often referred to as the "Doctor's Plan," will have been in operation for nearly fourteen months. The growth in number of certificates issued for prepayment medical care and resources is spectacular. As experience proved the financial advisability of providing more coverage for the insured, additional coverage has been written into the certificates.

Since authorization was given by the House of Delegates for the organization of the prepayment medical insurance company, and funds were advanced by physicians to finance it, the medical association has a tremendous responsibility in Mutual Medical Insurance, Inc. In the public's mind the company acts for, and in behalf of, the medical profession. Because of this close alliance, the success of the corporation is of deep concern to the association.

Change in Annual Session Program

Upon recommendation of the Executive Committee the program for the annual session has been extended this year to three full days, concluding with the annual dinner on the third night. This will allow more time for scientific papers and permit the holding of meetings without conflict. Instructional courses have been added to the program for the first time for an out-of-Indianapolis meeting.

The Committee on Scientific Work and the various section committees have procured outstanding men in medicine for the programs, and the Committee on Convention Arrangements has done a skillful job in looking after entertainment. Indications are that the 1947 session will reach a new high in interest.

Two things could be done by the House of Delegates which would facilitate future annual sessions. First, the selection of the meeting place two years in advance, instead of one year, as is now done, and, second, picking a specific set period, as, say the last week of October, for the meeting. This action by the delegates would guarantee better convention arrangements. The American Medical Association chooses its convention cities three years in advance.

Fifty Year Club

Physicians who have practiced for fifty years or more have won the profound respect of members of the profession, and the committee believed that they merited recognition. The Council approved of a plan to signal out these oldsters for special commendation at the annual dinner. Appropriate lapel emblems and a framed certificate of distinction will be bestowed upon them. Year of graduation from medical school will be taken as the beginning date of practice. Names of the doctors to be honored will be certified to headquarters office by the county medical society secretaries. The awards will be made every year at the annual session as doctors become eligible. It is expected to become a popular event.

Annual Registration Law

Despite articles printed in THE JOURNAL and newspapers, many doctors did not know that under a 1947 act of the General Assembly they are now required to register annually with the Indiana State Board of Medical Registration and Examination. They had to register before August 31 this year or their license to practice would be canceled automatically. In order to prevent any member from being embarrassed by losing his license, although it could be reinstated by payment of the $5.00 fee plus a penalty charge, postal cards of warning were mailed all members by direction of this committee.

"Doctors Then and Now" Broadcast

A dramatization of the first successful cholecystotomy, performed by Dr. John S. Bobbs of Indianapolis, was broadcast over a national radio hookup January 25, 1947. The broadcast also included a talk by the president of the state association. The program was Indiana's participation in the American Medical Association's "Doctors Then and Now" radio series, which was a part of the centennial observance of the A.M.A. Dr. Charles N. Combs of Terre Haute assisted in preparation of the script.

Assistance Given Woman's Auxiliary

Believing that the Woman's Auxiliary can make a definite contribution in the interest of medicine, the group was given financial help in publication of a bulletin, "The Hoosier Doctor's Wife," which is being sent auxiliary and prospective members. The membership goal is 2,000. A program for 1947-48 was approved by the Bureau of Publicity, and the county units can be expected to show results. Recruitment of girls for nurses training schools is the number one objective.

State Cancer Control Program

A three-point program for cancer control activities of the State Board of Health was agreed upon by the committee, the Committee on Control of Cancer, and the state health commissioner. Education of the laity, education of physicians in new developments in cancer diagnosis and treatment, and establishment of a cancer registry were the activities approved by the Executive Committee and the Council.

Hospital Building Program

The hospital and health center construction program of the State Board of Health through funds made available by the Hill-Burton Bill and raised locally by taxation or public subscription received the committee's approval. The program was studied by the Committee on Medical Education and Hospitals, which recommended its adoption, but not without flashing some "caution" signals. To this the Council agreed.

New Contract with VA

The Veterans Committee was authorized to enter into a new contract with the Veterans Administration for the care of ex-servicemen of World War II. Changes from the original contract were, for

the most part, minor. Through this arrangement veterans receive medical care in their home cities and from the private practitioner. The Veterans Committee has conferred frequently with the Executive Committee. The veterans medical care program is being handled extremely well, and great credit is due this hard-working committee.

General Practice Board

Assistance was given the Indiana Board of the General Practice of Medicine, Inc., which was organized by authority of the House of Delegates in 1946, until the early part of this year. Personnel and facilities of the headquarters office were made available to the board until it was in a position to establish its own office, with part-time secretarial help.

Federal Legislation

Two hundred copies of a booklet exposing the individuals and the forces behind the movement for compulsory health insurance as provided in the Wagner-Murray-Dingell Bill now before Congress were purchased and distributed to officers of the state medical association and the county medical societies. The booklet was written by Marjorie Shearon, Ph.D., and bore the title "Blueprint for the Nationalization of Medicine."

The Indiana General Assembly

Members of the Executive Committee kept in close touch with medical legislation during the recent session of the state legislature, working hand in hand with the Committee on Public Policy and Legislation. The members, individually, made contracts with legislators and joined in working for passage of beneficial health legislation and opposing bills considered to be against the best interests of the public.

Membership at New High

The membership of the association has shown a continuous gain since the release of physicians from military service. On August 1, 1947, the paid-up membership was 3,546, an all-time high. The increased income from dues has strengthened the association's finances. Comparative figures follow:

Year	Number of Physicians in Indiana	Regular Members	Honorary Members	Total Members
1944	4,165*	3,197**	129	3,326
1945	4,165	3,187***	142	3,329
1946	4,165	3,251****	155	3,406
1947	4,165	3,374*****	172	3,546

* Figure taken from the latest directory of the American Medical Association.

** Includes 936 men in service who received membership gratis.

*** Includes 1,019 men in service who received membership gratis.

**** Includes 831 men in service who received membership gratis.

***** Includes 117 men in service who received membership gratis.

THE JOURNAL

Despite the critical shortage of print paper, which necessitated curtailment of some issues of THE JOURNAL, the page average for the twelve issues during the past year was the highest in the history, being 126.7. This record was achieved because our printers, C. E. Pauley & Company, Inc., of Indianapolis, had connections with numerous paper companies and could procure the scarce high grade enamel stock which we use.

The following table is a breakdown of JOURNAL pages for the past six years:

Year	Reading Pages	Per Cent Reading	Adv. Pages	Per Cent Adv.	Total Pages	Aver. Pages Per Issue
1941	728	59	506	41	1234	102.8
1942	752	61	488	39	1240	103.3
1943	736	59	516	41	1252	104.1
1944	758	56	588	44	1346	112.1
1945	580	44	754	56	1334	111.1
1946	696	46	824	54	1520	126.7

Medical Year Book Number

The year was marked by several innovations, the most outstanding of which was the "Indiana Medical Year Book" issue in January 1947. In the place of scientific articles, this number carried widespread economic information, including a list of all members of the state association in alphabetical order and by their county medical society affiliations, and extra advertising. More than 150 extra copies of this issue were sold. It was so well received that the Editorial Board voted to make it an annual event.

Two New Features

Two new features were added to THE JOURNAL pages: "Medical Panorama," by the associate editor, and "What's Going on in Indiana," by the executive secretary. These columns bring the readers reports on medical activities within Indiana and elsewhere. They are the answer to a demand for better reporting of medical affairs by THE JOURNAL.

Four Art Covers

In addition to the specially-designed cover of the "Indiana Medical Year Book," three issues of THE JOURNAL have carried attractive art covers. This deviation from the ordinary cover pattern has enhanced the attractiveness of THE JOURNAL. Use of the picture of the president-elect of the American Medical Association on the cover of the July issue was precedent-breaking, and gave deserved recognition to a prominent Hoosier physician.

Three special issues appeared in the past twelve months—The Medical Year Book, Conservation of Vision, and General Practice numbers.

Library is Sold

THE JOURNAL had a library of approximately five hundred books which had accumulated over a period of fifteen years. The publishers sent the books to THE JOURNAL for reviewing. The volumes were seldom used and took up space which could be better

utilized, so they were sold to the highest bidder on instructions of the Editorial Board. All county medical societies were notified. Of three bids received, the Union Hospital of Terre Haute was the highest.

Printing

The printing contract with C. E. Pauley & Company, Inc., of Indianapolis, was continued for another year, despite a 100 per cent boost in the cost per page since June 1, 1946. The firm was requested to review its cost sheets to see if JOURNAL expenses could be reduced, but the firm was unable to do so because of increased labor and material costs. Pauley's opened its books to us for inspection. Apparently we cannot do anything but "take it." The firm has promised us a reduction wherever it is feasible. We have practiced many economies and are glad to report that THE JOURNAL over-all operating expenses have increased only $1,500 for the first six months of 1947.

Advertising

The average number of advertising pages per issue has continued to increase, in conformity with the trend of former years. This gain in income has offset the increase in printing costs, to a degree. There has been an increase in direct advertising, as well as in Cooperative Medical Advertising Bureau accounts.

A comparison of advertising revenue for the first six months of 1947 follows:

First 6 months	1944	1945	1946	1947
Bureau agency	$3,487.58	$6,114.28	$8,459.62	$9,779.78
Direct	2,507.32	2,766.18	4,295.43	5,167.11
Total	$5,994.90	$8,880.46	$12,755.05	$14,946.89

Advertisers want concrete evidence of the value of their advertising; therefore members of the association can materially increase the advertising revenue of THE JOURNAL by answering keyed and coupon ads.

THE JOURNAL Personnel

This report would not be complete without some acknowledgment of the services performed by the editor, Doctor Shanklin. He is completing fifteen years in this capacity, and during this period THE JOURNAL grew into full manhood under his tutelage. The editorship is a hard job, a thankless one at times, but Doctor Shanklin has done it very well.

The associate editor, the managing editor, and the two ladies in THE JOURNAL office have worked faithfully with the editor to produce what we can proudly say, without fear of contradiction—the best state medical journal in the United States.

Medical Defense Activities

1. *Malpractice cases.* A years ago, at the time of this report, August 1, 1946, the following fourteen cases were pending before the committee, five of which were closed during the year, leaving nine cases still pending:

Case No. 200—Suit filed February 2, 1932. Pending.

Case No. 230—(Closed.) Suit filed November 18, 1939. Statement for attorney's fees not yet received.

Case No. 241—Suit filed February 7, 1941. Pending.

Case No. 242—Suit filed January 28, 1942. Pending.

Case No. 249—Suit filed January 6, 1944. Awaiting trial.

Case No. 250—Suit filed December 7, 1944. Pending.

Case No. 251—Suit filed September 25, 1942. Pending.

Case No. 252—Suit filed August, 1944. Awaiting trial.

Case No. 254—(Closed.) Suit filed August 1, 1945. Case dismissed January 2, 1947. Expense $100.00, paid March 17, 1947.

Case No. 255—Suit filed September, 1945. Pending.

Case No. 256—Suit filed February 27, 1946. Pending on questions regarding the form of complaint.

Case No. 257—(Closed.) Suit filed December 5, 1945. Case dismissed March 7, 1947. Expense, $150.00, paid March 17, 1947.

Case No. 258—(Closed.) Suit filed December, 1944. Settled for $200.00 and dismissed, 1947. Statement for attorney's fees not yet received.

Case No. 259—(Closed.) Suit filed December, 1945. Seven days' trial; judgment for defendant. Attorney's fees not yet paid.

Since August 1, 1946, and up to August 1, 1947, the following four new cases have come before the committee, one of which has been closed, making a total of twelve cases pending at the present time as against fourteen unclosed cases at the same time last year:

Case No. 260—Suit filed July, 1946. Pending on a demurrer to the complaint and awaiting argument on the demurrer.

Case No. 261—(Closed.) Suit filed "about 1942." Settled for $300.00 and cause dismissed March 25, 1947. Expense, $150.00, paid April 22, 1947.

Case No. 262—Suit filed January 4, 1947. Plaintiff took appeal from judgment for defendant to Appellate Court, where case is now pending.

Case No. 263—Suit filed December 19, 1946. Awaiting trial.

2. *Medical Defense Fund Statement*, from August 1, 1946, to August 1, 1947:

Balance, August 1, 1946		$3,895.98
RECEIPTS:		
Dues, 126—1946 members	$94.50	
3,362—1947 members	2,521.50	2,616.00
Interest on bonds		350.00
		$6,861.98
DISBURSEMENTS:		
Malpractice fees	$500.00	
Salary of Association attorney	1,800.00	2,300.00
Balance in Medical Defense Fund checking account, August 1, 1947		$4,561.98

C. H. MCCASKEY, M.D., *Chairman*
W. L. PORTTEUS, M.D.
FLOYD T. ROMBERGER, M.D.
C. A. NAFE, M.D.
ALFRED ELLISON, M.D.

INSTRUCTIONAL COURSE COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Instructional Course Committee wishes to report that at the 1946 annual session at Indianapolis, twenty-five classes were offered on Tuesday, October 29. Each class was limited to an attendance of thirty, and each class was fully attended by subscribing students.

The subjects covered included material of current value in the fields encontered in general practice and were offered with the idea of providing the general practitioner with information on medical progress and with the tools by which he could employ such progress.

The response of the students to these courses was enthusiastic and pleasing to the committee. We feel that they are now such an established part of the convention program that their continuance as an annual feature should not be questioned. We believe that they provide short, intense postgraduate instruction of the finest caliber.

The committee for the 1947 instructional course program has arranged a curriculum of twenty-five subjects, modified by experience of the past years and by current medical progress. The attendance this year promises to be a capacity enrollment.

It is recommended by the committee that the organization and offering of these courses be in the hands of a committee, the membership of which does not change completely in any two consecutive years, as the organization of such a curriculum is a complicated process.

GORDON W. BATMAN, M.D.,
RUSSELL A. SAGE, M.D., } *Co-chairmen.*
FRANK B. RAMSEY, M.D.,
J. LAWRENCE SIMS, M.D.,
BRANDT F. STEELE, M.D.,
FLOYD T. ROMBERGER, JR., M.D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The beginning sentence of an article entitled "Physicians Required to Register Under New Law; A Report on the 1947 Legislature" (page 355 of the April Journal) might well be the report of this committee to your honorable body. It reads: "Indiana medicine got mostly what it wanted . . . and didn't get what it didn't want . . . from the 85th General Assembly. . . ." In a nutshell, that is the essence of your committee's activity so far as the 1947 state legislature is concerned.

The article referred to gave a comprehensive report on legislation of interest to the medical profession, and for the sake of brevity the facts will not be repeated here. It is requested that THE JOURNAL article be considered as part of this report.

Local Legislation

Fifteen bulletins about legislation were issued before, during, and after the session ended, to legislative committees and officers of county medical societies and to officials of the state association. Members of the Committee on Public Policy and Legislation met frequently during the sixty-one days the General Assembly was in session, and personal contact was maintained with individual members of the legislature. Excellent help was given the committee by the attorney and executive secretary of the state association, and the executive secretary of the Indianapolis Medical Society. When appeals went out to individual physicians to contact their senators and representatives the response, and the results, were most gratifying.

Registration Law

In accordance with the House of Delegates' action in 1945, a bill calling for the annual registration of all licensees of the Indiana State Board of Medical Registration and Examination, specifying that the registration fee be $2.00, was introduced. It will be recalled that the purpose of such a law was provided the board with sufficient funds to employ investigators and other personnel so that it could enforce the Medical Practice Act.

The bill passed the senate without dissent, but when it reached the Committee on State Medicine of the house, the chairman attempted to amend the bill to raise the annual registration fee to $20.00. Our Committee on Public Policy and Legislation opposed this drastic increase. Finally, the chairman came down to $10.00. After another vigorous fight within the house committee, a registration fee of $5.00 was agreed upon. We were told the bill would die in committee unless the medical profession accepted the $5.00. The State Budget Committee supported the position of the Committee on State Medicine.

A telephone poll was made of officers of the association and members of the council, the question being, should we accept the $5.00 fee and have enforcement of the Medical Practice Act, or not. It was the opinion of the officers and councilors, with one exception, that it was to the best interest of medicine to have the registration law despite the fact that the fee was $3.00 more than designated by the House of Delegates. Investigation revealed that $5.00 is in line with fees other professional men pay into the state annually. The

bill passed the house with only one negative vote and became law upon the Governor's signature.

Physicians Should Be Legislators

Attention of the House of Delegates is called to the fact that the profession was handicapped because no physician was a member of the house or senate. Physicians should be urged to become candidates for the legislature. The salary is now $1,200 a year.

Federal Legislation

Medical organizations at the national level—the American Medical Association in particular—are depended upon to support or oppose health legislation in Congress. None of the bills objectional to the profession advanced very far in the first session of the 80th Congress. Your committee was alerted at all times and ready to spring into action if called upon.

In 1948 Congress is expected to become a battleground over health legislation, including the new Wagner-Murray-Dingell bill. While the political complex of Congress has changed, it must not be taken for granted that the danger of compulsory health legislation has passed. Medicine dares not relax its vigil.

NORMAN M. BEATTY, M.D.,
J. WILLIAM WRIGHT, M.D., } *Co-chairmen,*
GEORGE DANIELS, M.D.,
J. R. DOTY, M.D.,
HAROLD J. HALLECK, M.D.,
O. T. SCAMAHORN, M.D.,
ROBERT L. GLASS, M.D.,
JOHN M. PALM, M.D.,
WALTER F. KELLY, M.D.,
A. N. FERGUSON, M.D.

BUREAU OF PUBLICITY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Meeting twenty-one times during the year, the Bureau of Publicity has kept a steady stream of information on health subjects flowing to the laity through the medium of the public press, the radio, and the speaker's platform. In addition, news releases covering activities of the association, and pamphlets pointing out the evils of the proposed federal compulsory health insurance, have been distributed.

In acting as a clearinghouse for information emanating from the state medical association, the bureau members have been conscious of the responsibility reposed in them, and have weighed each decision carefully. Professional ethics of the profession have been kept constantly in mind. All scientific information has been diligently checked before it has been approved for release.

Broadly speaking, the program of the bureau has a twofold aim. First, it is to supply the public with accurate information about scientific medicine and the attitude of the medical profession upon matters of public concern. Under this category, too, comes newsworthy facts about the association's own activities. Second, development of a better understanding between the public and the profession. This is done through proper portrayal of medicine's deep interest in better health for the people.

Newspaper Releases

Seventy-one news releases were approved by the bureau during the 1946-47 year. Fifty-two of them were "Hints on Health" columns which went exclusively to weekly newspapers, and nineteen were sent to both dailies and weeklies. Ninety-one weekly papers are using the "Hints on Health."

Health columns were written on the following subjects:

Control of Rabies.
Food Poisoning.
Spastic Colitis.
Rats Are A Menace.
Ringworm of the Scalp.
Treatment of Warts.
Find Eczema's Cause.
Childbirth Deaths Cut.
Gallstone Symptoms.
Arthritis in Broad Term.
The Effect of Athletics.
Avoid Sleeping Pills.
Cold Time Is Here.
Diphtheria.
Fibroids Are Common.
Pernicious Anemia.
Gall Bladder Disease.
Rabbit Fever.
Growing Pains.
Epilepsy.
Heart Murmurs.
Vaccination Musts.
Lunch Box Nutrition.
Chronic Diarrhea.
Shingles.
Care of the Kidneys.
Postnasal Discharge.
Causes of Dropsy.
Body Needs Calcium.
The Lingering Cough.
Migraine Headache.
Stomach Ulcer.
Eat Adequate Breakfast.
Acute Pleurisy.
Promiscuous Spitting.
Muscular Rheumatism.
Psoriasis.

Don't Neglect Hernia.
Bladder Control.
Baseball Finger.
Cause of Stroke.
Mastoiditis.
Birthmarks.
Early Hay Fever.
Care of the Feet.
Adolescent Acne.
Danger in Self Aid
Astigmatism.
Losing Weight.
Tests of Allergy.
Paralysis Agitans.
Heat Exhaustion.

The twenty general news releases were:

Artificial Respiration Saves Lives.

Indiana State Fair.

1946 Annual Session (six releases).

National American Legion Resolution Opposing Compulsory Health Insurance.

Yule Happiness Jeopardized by Threat of Fire.

Article on American Medical Association—NBC Dramatization of Dr. John S. Bobbs.

Social Hygiene Day—February 5.

Measles Should Be Regarded as Serious Disease.

Wild Mushrooms Can Kill.

Swimming Called Safest Exercise for Hot Weather.

Hoosier Physicians Pick October Dates for Annual Meeting.

Medical Paintings Will Be Exhibited by State Doctors.

Quick Action Often Prevents Crippling when Polio Strikes.

Overuse of Nose Drops May Prove Harmful.

Article about 1947 Officers and Committees.

Radio Programs

The policy of using American Medical Association transcriptions on health subjects has been followed through co-operation of WFBM, an Indianapolis radio station. Fifteen minutes a week are given the state medical association without charge, and the bureau wishes to thank publicly the management of WFBM for donating its services to Indiana Medicine. The programs go on the air at 9:15 every Monday morning.

The programs procured from the A.M.A. are much better than the bureau could produce itself, because the A.M.A. has access to big name medical and entertainment talent. The bureau has urged county medical societies having local radio stations to get these recordings for local broadcast. The transcriptions are supplied without charge.

The titles of the radio series used are:

Melody of Life.
Why Do You Worry?
The Public Comes First.
More Life For You.
Fair and Cooler.

Speakers Supplied

When the state medical association is called upon to supply speakers for any occasion, it is the duty of the bureau to procure them. Getting physicians to fill speaking engagements is difficult, for many are too busy or do not regard themselves as capable of speaking. If more doctors would accept speaking engagements, it would be helpful in getting medicine's story to the people, particularly as to why medicine is against federal legislation such as the Wagner-Murray-Dingell bills, and the like.

Organizations supplied with speakers follow:

1946

September 11—Shelby County Medical Society
September 19—American Federation of Labor Convention.
September 19—LaPorte County Medical Society.
November 15—Woman's Auxiliary, St. Joseph County.
November 15—Cass County Medical Society.
December 3—Boone County Medical Society.

1947

February 21—Woman's Auxiliary, Marion County.
May 20—Woman's Auxiliary, Delaware County.
May 21—Decatur County Medical Society.
May 22—First District Medical Society, Princeton.
May 22—Southwest Regional Conference, Indiana State Conference in Social Work.
June 5—Indiana State Federation of Clubs, Indianapolis.
June 12—Second District Medical Society, Linton.

Woman's Auxiliary

The Bureau, by designation of the Council some years ago, acts as the Advisory Committee to the Woman's Auxiliary. In this connection, the bureau suggests subjects for discussion by the various county auxiliary units, and types of activities for them to engage in throughout the year. In drawing up the suggested program for the auxiliary in 1947-48, the bureau has listed enrollment of girls in nurses' training schools as its Number One Objective.

The bureau is glad to note the growth of the auxiliary and wishes to recommend that each county society without an auxiliary encourage the formation of a unit. The doctor's wife can be of definite

help to organized medicine and we believe her talents should be utilized.

Material Sent Debate Teams

The bureau supplied more than a hundred Indiana high school debate teams with arguments against compulsory health insurance. The material was helpful because the subject debated by the pupils was whether or not the federal government should establish compulsory health insurance. The debate coaches were sent two pamphlets obtained from the Council on Medical Service, American Medical Association, entitled "Voluntary Health Insurance vs. Compulsory Sickness Insurance" and "An Outline of Arguments Against Compulsory Sickness Insurance." In addition, the bureau purchased copies of a booklet entitled "Check and Double Check on Sickness Insurance," issued by the Public Relations Bureau of the Medical Society of the State of New York, which also went to the debate coaches.

Financial Statement

The expenditures of the Bureau of Publicity from August 1, 1946, to August 1, 1947, follow:

Clippings	$22.65
Postage	108.14
Stationery and mimeograph supplies	62.24
Printing	517.22
Miscellaneous	55.58
	$765.83

HOMER G. HAMER, M.D., *Chairman,*
DAVID L. SMITH, M.D.,
BEN B. MOORE, M.D.

COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Civic and Industrial Relations had nothing referred to it during the year and therefore has no report to make at this time.

FRED B. WISHARD, M.D., *Chairman,*
PHILIP E. YUNKER, M.D.,
A. C. REMICH, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Relative to the hospital expansion plan set out by and to be implemented by the State Board of Health in conjunction with the Hill-Burton Act *S. 725*, we feel that at the outset a few notes of warning should be sounded.

1. It is our conviction that in the past there has never been nor should there ever be any major disagreement between the private practice of medicine and the maintenance of the public health services by legally constituted authority.

2. The possibility of bureaucratic control over the private practice of medicine should be duly considered.

3. Since general medical practice is the backbone of medical service due consideration should be given this group.

In view of the need for more hospital beds in this state, and because of the rather general expression of preference for this plan over those previously proposed, we recommend its acceptance by the Indiana State Medical Association.

E. N. KIME, M.D., *Chairman,*
C. J. CLARK, M.D.,
O. O. ALEXANDER, M.D.,
HERMAN M. BAKER, M.D.,
HARRY P. ROSS, M.D.,
HARRY E. KLEPINGER, M.D.

COMMITTEE ON PUBLIC RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Council of the Indiana State Medical Association refered to this committe the question as to whether or not the association should sponsor postgraduate instruction. The subject was discussed by the committee at a meeting on July 13, and the following report was referred to the Council and approved by it on July 20:

"The chairman and Mr. Smith decided that a study of this matter would be greatly helped if we could determine the desire of the physicians of the state for postgraduate instruction. We therefore sent out a questionnaire to the secretaries of the county and district societies asking for information on:

(1) Whether or not they desired instruction;
(2) Whether or not they wished it given at regularly scheduled meetings;
(3) How far did they think their members would be willing to go to meetings.

"There was a good return of these questionnaires. Nearly all the secretaries wanted the instruction and wanted it given at regularly scheduled meetings. Most of them wanted it given as near home as possible, at least in their own districts. Very few wanted it given at Indianapolis.

"This is what one would expect to get from the secretaries and does not prove that the physicians of the state are eager for instruction.

"The committee discussed the subject at length and all agreed that nearly all attempts to give postgraduate instruction in the past had been failures —often humiliating failures. The members also agreed as to the reasons for these failures, chief of which are:

(1) A poor method of instruction—almost entirely by lecture.

(2) Lack of continuity in program.

(3) Lack of any possible method of determining what the students had learned.

(4) Discouraging lack of interest.

"Our attempts at instruction have ignored the first principle of education, namely, that the student must educate himself.

"The committee was of the opinion that—

(1) To devise and put in operation an effective system of postgraduate instruction would require time and the expenditure of very large amounts of money.

(2) That centers of postgraduate instruction should be established in various parts of the state, in well-equipped hospitals where continuous courses similar to those given at St. Elizabeth's Hospital, Lafayette, could be given.

(3) That as an interim measure the association should prepare a list of speakers and a list of subjects for the benefit of county and district secretaries; the speakers not to be limited to physicians, and the subjects not entirely to medical subjects.

(4) That the association do whatever it can to aid the establishment of good medical libraries in various teaching centers of the state.

(5) That the association correlate its postgraduate work with that of the Indiana Board of General Practice of Medicine."

The committee had no other meeting, but an attempt was made to get out an additional report by correspondence. This was only partially successful, but all the members agreed that our most important public relation is the service that we as a profession and as individual doctors give to the public. The committee emphasizes strongly that the most important means in our possession for keeping the good will and support of the people is to give them satisfactory medical service. It believes that if we can do this we need have no fear of state regulation of medical practice. It believes that every physician should practice medicine as a learned profession and not as a trade and that we have heard in recent years more of the "business management" of our practice than is good for us.

W. D. Gatch, M.D., *Chairman*,
F. S. Crockett, M.D.,
J. E. Ferrell, M.D.,
Norman R. Booher, M.D.

Ex-officio:

Ray E. Smith,
Rollis S. Weesner,
Joseph E. Palmer.

THE JOURNAL

We of the editorial staff are mighty proud of the 1947 Journal; we believe that we have brought to you, each month, the finest product in the long history of our magazine.

Not long ago the sales manager of one of the world's largest printing establishments was in our office and picked up a copy of our magazine; he asked to see other copies and, after looking them over, thumbing the paper, and taking quite critical glances at the format, remarked, "That is one of the finest bits of printing I have seen in years!" This man had spent more than forty years in the printing industry and knew not only its mechanical phases, but was well versed in the reading material portrayed in the pages. We felt that indeed we were being complimented by an expert and were accordingly proud of his pronouncements.

All this, however, has been accomplished with no little effort. The printing industry of 1947 found many new obstacles in its path; these, in the main, have been surmounted, by dint of the combined efforts of everyone connected with our publication. We have had excellent co-operation from our printers, despite the fact that your magazine has not been laid on your desk on the first of every month; delays in the "print shop" have been unavoidable, the press of other work has slowed us up on many occasions, but when your Journal reaches you you are at once aware that it is a smart, up-to-the-minute production.

No one individual, or even a small group of individuals, is responsible for the excellency of *your* magazine; rather is it a *co-operative* product. Your editorial board has had much to do with this; Ray Smith, your managing editor, has done a magnificent job of it, this year of 1947. Doctor Forster, the associate editor, has proved to be a "find"; without his assistance we would have been utterly swamped.

Then The Journal office force, Mrs. Rowlison and Miss Stanley, have done big things—and done them exceedingly well.

Nor can we overlook the "front office," from which comes the able support of Miss Kribs and Miss Reid; every call we have made upon them has met with an immediate response.

Then, of course, comes our scientific contributors, practically all of them from our own members. Time was, and not so long ago, that we often were put to it to find sufficient material for our scientific section; today, we have a sizeable back log of material that most any medical editor would like to have in his files.

Our advertising has kept pace with the rest of the magazine and recent reports from C.M.A.B. indicate that we may expect a continuation of this support for 1948.

Printing costs have risen enormously; right now we are paying more than double the page cost of

a year ago, and it seems probable that this will mount even higher in another year.

We frankly believe that THE JOURNAL is entitled to an increase in our per capita payment. Now we receive from the general fund of the state association two dollars per year, per member; we believe that should be increased to at least two dollars and fifty cents. With the increase in Association income we feel that this slight increase will mean no particular hardship to the parent organization—it will mean that your magazine may be expanded.

THE JOURNAL looks forward to 1948 with much anticipation; we firmly believe that a year hence, when another report is made, we will be able to present many improvements—a better, bigger magazine for our readers.

E. M. SHANKLIN, M.D., *Editor.*

COMMITTEE ON SECRETARIES' CONFERENCE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The annual Secretaries' Conference was held January 12, 1947, at the Claypool Hotel, with Dr. A. M. Mitchell, chairman, presiding. Dr. Cleon Nafe, president-elect of the Indiana State Medical Association, made the address of welcome.

Dr. L. E. Burney and Dr. J. William Wright reported on legislative matters. Dr. Homer Hamer reported on the meeting of the House of Delegates of the American Medical Association. Dr. Charles F. Thompson reported on Veterans Administration affairs. Dr. W. U. Kennedy detailed the activities of the Mutual Medical Insurance, Inc. Dr. E. M. Shanklin talked about the State Journal. Dr. J. S. DeTar, chairman of the Public Relations Committee of the Michigan State Medical Society, was the guest speaker for the afternoon. He gave a very interesting talk on public relations. Mrs. S. J. Petronella, president of the Woman's Auxiliary, offered suggestions as to how the auxiliary and the state association might work together. Miss Nancy Scramlin, president of the Indiana Nurses Association, talked about the shortage of nurses. Dr. H. M. Smith of Brookville, read a paper on rural medical care. At dinner, Dr. Floyd T. Romberger, president of the Indiana State Medical Association, gave a talk on county medical societies, and Dr. George F. Lull, secretary and general manager of the American Medical Association, gave a talk on "American Medicine Looks to the Future."

Dr. A. M. Mitchell was re-elected chairman for 1947.

A. M. MITCHELL, M.D., *Chairman,*
O. E. WILSON, M.D.,
ABRAHAM M. OWEN, M.D.,
GLEN W. LEE, M.D.,
J. T. CARNEY, M.D.

COMMITTEE ON NECROLOGY AND HISTORY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The report on necrology is published annually in the earliest possible number of THE JOURNAL.

In history, no meetings have been held and no work accomplished this year.

JAMES B. MAPLE, M.D., *Chairman,*
W. D. INLOW, M.D.,
L. G. ZERFAS, M.D.,
E. R. CLARKE, M.D.,
ROBERT H. PIERSON, M.D.,
HARRY H. SANDOZ, M.D.,
CHARLES F. LEICH, M.D.

COMMITTEE ON MENTAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Mental Health of the Indiana State Medical Association met in Indianapolis on August 2, 1947, with the following members present: Drs. L. P. Harshman, Fort Wayne; G. E. Metcalfe, South Bend; H. C. Buhrmester, LaFayette, and A. M. DeArmond, Indianapolis, chairman. As nothing had been referred to the committee, no action was taken. The committee expressed confidence in the Indiana Council on Mental Health and offers its assistance to that Council.

A. M. DEARMOND, M.D., *Chairman,*
L. P. HARSHMAN, M.D.,
G. E. METCALFE, M.D.,
W. L. SHARP, M.D.,
H. C. BUHRMESTER, M.D.,
E. V. HAHN, M.D.

COMMITTEE ON MATERNAL AND CHILD HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

In presenting our report on Maternal and Child Health activities in the State of Indiana during the past year, we wish to state that more matters of interest have transpired than in any year since the beginning of the war, and we wish to present several resolutions of the committee which we consider important for action by the House of Delegates of the Indiana State Medical Association.

Following is a report of the Maternal and Child Health activities of the State Board of Health, the status of the Emergency Maternity and Infant Care Program for soldiers' families, and the activities of the committee as it concerns these programs, and its resolutions concerning other matters.

Of first interest was an action taken by the committee to change its name, with the permission of the president of our association, Dr. Floyd T. Romberger. When it was established the committee was given the name, "Advisory Committee to the Division of Maternal and Child Health of the State Board of Health." The committee was given this name and established when the Division of Maternal and Child Health of the State Board of Health was established by an act of the state legislature in 1936. The committee has felt, for some time, that this name was cumbersome and that it did not cover the real scope of endeavor of the committee, since the committee is interested in all phases of the field of maternal and child health, and not just in its specific duties as Advisory Committee to the State Board of Health. For these reasons the committee took action to change its name to "Committee on Maternal and Child Health." The committee will, of course, continue in an advisory capacity to the State Board of Health, but it has resolved to extend its interests in accordance with the general needs in this field.

Close of the EMIC Program

During the current year, authorizations for care under the EMIC Program diminished to about 10 per cent of the case load during peak years. Authorizations for both maternity and pediatric care have diminished to less than 200 per month. Action has been taken by Congress to bring the program to a close with the following conditions: Funds will be available during the fiscal years 1948 and 1949 for the completion of maternity and infant care authorized prior to June 30, 1947, and for maternity and pediatric care authorized after June 30, 1947, if the expectant mother or the mother of an infant was pregnant and eligible for care prior to June 30, 1947. This will continue the program for a final termination at a time not later than 21 months after June 30, 1947.

A study was made of the costs of administration of the EMIC Program and it was reported that the total costs of administration were 3.74 per cent of the cost of the entire program, including all medical and hospital services.

Attention is called to detailed reports on the entire program which were published in the Indiana State Board of Health Monthly Bulletin, for April, 1947, and earlier in April, 1944, 1945, and 1946.

Maternal and Infant Mortality and Morbidity

An extensive study was conducted on hospital mortality and morbidity statistics in the maternity and newborn services of hospitals in the State of Indiana for the years 1943, 1944, and 1945. This study was made for the committee by Dr. Jewett, Dr. Stoeffler, Miss Mary Ellen Warstler, and Mr. Serfling, of the State Board of Health, with the chairman of this committee as consultant. This statistical material contains facts pertaining to maternal and infant deaths, premature deaths, and the Caesarean Section rates in hospitals for the years covered by the study.

An additional study pertains to the rate of premature deaths and the percentage of prematures that died. All of the facts indicate a wide variation in the facilities and services in the various hospitals throughout the state. These statistical analyses showed significant differences in the rates of death of premature infants in the various hospitals.

There is a wide variation in the rate of premature deaths, the leading cause of newborn deaths, due to a lack of facilities and a lack of adequately trained personnel in many institutions. It is a known fact that qualified personnel are scarce and that there is a great necessity for graduate training of nursing personnel in the care of the premature infant.

It was noted that the percentage of hospital births was very low in many localities and approached 100 per cent in some of the metropolitan areas. Mortality rates and premature deaths are in accord with these differences in hospital births. Of great interest was the fact that the percentage of births by Caesarean Section varies widely and that there is a much higher percentage of Caesarean Section births in the middle-sized or average county hospitals, and this varies widely in this type of institution, being alarmingly high in certain specific counties. A detailed study will appear in the November issue of THE JOURNAL.

American Academy of Pediatrics Child Care Survey

The Child Care Survey sponsored by the American Academy of Pediatrics was completed during the year by Dr. Walter Stoeffler, Pediatric Consultant for the State Board of Health, acting as Executive Secretary for the Indiana section of the Academy. The survey material will be sent to the American Academy of Pediatrics Headquarters in Washington, D.C., for analysis. The material and the completed analysis will be returned to the State Committee of the American Academy of Pediatrics and placed in the hands of Dr. E. R. Carlo of Ft. Wayne, the committee chairman. The report on the survey analysis will be available to the Committee on Maternal and Child Health of the State Medical Association.

Other Activities of the State Board of Health

The State Board of Health continued other established Maternal and Child Health activities which include public health nursing services, well-child conferences, prenatal clinics, and dental health programs. Other approved activities include the Brown County Mid-wife Service under the direction of a local practicing physician, assistance in the conduct of the Herman G. Morgan Health Center for colored people in Indianapolis, and the Carver Health Center for colored people in Evansville.

Other important programs of the State Board of Health included guidance services in the care of premature infants and the providing of thermo-

statically controlled incubators on a loan basis for home and hospital use upon the request of attending physicians.

In addition, medical and hospital care was provided for unmarried mothers and for children born out of wedlock, where family resources were limited and assistance and care was not available from other agencies.

Activities of the Committee on Maternal and Child Health

The committee gave consultative guidance to the Maternal and Child Health Program of the State Board of Health and, in addition, it reviewed certain problems brought to the attention of the body by members of the committee, and it acted upon several resolutions of importance to the state medical association.

Maternal and Child Health problems were considered by the committee, through personal interest, correspondence, and verbal communications, and actions on certain of these problems were officially taken at the meeting of the committee held in Indianapolis on June 25, 1947.

The problems reviewed by the committee and the actions taken are reported in order:

1. Care for Unmarried Mothers and Children Born Out of Wedlock.

Medical and hospital services for unmarried mothers and for children born out of wedlock were considered. It was agreed that there was a great health problem and a great social problem in this field, that some services might be provided, but that such assistance should not be given wherein adequate resources and adequate facilities were available from existing public or voluntary social agencies.

In regard to the continuation of medical and hospital assistance for unmarried mothers and children born out of wedlock, the committee resolved:

> That the State Board of Health continue to provide medical and hospital care for those individuals unfortunate enough to give birth to illegitimate children and for the children born out of wedlock, in such instances where other agencies are unable or unwilling to provide assistance, in order to secure a backlog of security in maintaining proper and adequate care.

2. Institutional Care for Defective Children Under Six Years of Age.

The committee considered the serious need for institutional care for mentally defective children under six years of age. Existing state institutions will not provide such care for children under six. It was agreed that this was a very serious sociological and health problem, inasmuch as it placed a painful burden upon the parents. In regard to the serious lack of services provided by the state for these defective children, the committee resolved:

> That this committee ask that a resolution be introduced before the House of Delegates of the State Medical Association to instigate legislation to establish institutions, or expand institutions, to provide facilities and services for defective children under six years of age.

3. Hemorrhage as an Important Cause of Maternal Death.

The committee considered postpartum hemorrhage and the providing of consultative service to hospital laboratories to help in minimizing this cause of death. Hemorrhage is becoming a leading cause of death due to the better control of infection and toxemia. Deaths could be prevented if adequate blood was immediately available and if it was of a type compatible with the recipients. One of the major deficiencies responsible for the difficulties in obtaining proper blood is the lack of complete laboratory services in most of our smaller hospitals. It was agreed that a consultative service to hospitals to help up-grade laboratory techniques, and to establish techniques for determining the Rh factor, would be of considerable help. It was agreed that it would be a primary move to employ an experienced and qualified laboratory person to work under the Division of Laboratories of the State Board of Health and to act as a consultant to the laboratory services of hospitals.

Another factor in fluid replacements in hemorrhage was a frequently encountered difficulty in obtaining plasma for immediate use. Although plasma is provided free by the State Board of Health, there is a tendency for this plasma to be used without reservation on the surgical services. All members felt that the plasma supplied by the State Board of Health should, in part, be earmarked for obstetrical emergencies and used for no other purposes. In accordance with these thoughts, the committee resolved:

> That it be recommended that the State Board of Health employ a qualified laboratory technician to serve as consultant to hospital laboratories throughout the state, and that pending other and better facilities, the blood plasma supplied by the State Board of Health be, in part, earmarked for obstetrical emergencies alone and not released for use on surgical services.

4. Criteria for Classification of all Births.

The committee considered the present variability in terminology for abortion, premature death, birth, and stillbirth. The committee feels that some standards should be adopted by the State Medical Association for a definition of certain common terms. The committee resolved:

That Dr. Jewett of the State Board of Health be authorized to determine the most common definitions for abortion, premature birth, and stillbirth, and that the best terminology be recommended to the State Medical Association as standards for classification.

In accordance with this resolution, information was gathered regarding an acceptable criteria for classification of all births and submitted to the committee for approval. A classification was approved by the committee, and this places in force its resolve that this terminology be recommended to the State Medical Association as a standard classification subject to approval by the House of Delegates. The criteria approved and adopted by the Committee on Maternal and Child Health is as follows:

EARLY ABORTION—if any two of the following criteria are present:

1. Duration of gestation less than 22 weeks.
2. Fetal size less than 400 gm. (14.7 oz.).
3. Fetal length under 28 cm.

LATE ABORTION—delivery of a previable fetus if any two of the following criteria are present:

1. Duration of gestation 22 to 28 weeks.
2. Fetal size 400-1,000 gm. (14.7 oz. to 2.2 lbs.).
3. Fetal length 28 to 35 cm.

PREMATURE DELIVERY—if any two of the following criteria are present:

1. Duration of gestation 28 to 38 weeks.
2. Fetal size 1000-2500 gm. (2.2 to 5.5 lbs.).
3. Fetal length 35 to 47 cm.

STILLBIRTH—A stillborn child is one showing no evidence of life after complete birth, no breathing, no heart action, no movement of voluntary muscles. If the 20th week of gestation has been reached, the fetus must be registered as a stillbirth and a permit for burial secured.

5. Care of Premature Infants.

The committee gave long consideration to the problems of premature birth, premature mortality, and premature care. Statistical analysis shows a wide variation in the rate of premature deaths, the leading cause of newborn deaths throughout the state, due to a lack of facilities and a lack of adequately trained personnel in many institutions.

It is a known fact that qualified personnel are scarce and that there is a great necessity for graduate training of nursing personnel.

Since Indiana University Medical Center is a teaching center for the State of Indiana, the committee agreed that the University could not take a more important step in the control of mortality than to establish a premature care center for the purposes of giving direct service and for the training of nursing personnel. In accordance with these thoughts, the committee resolved:

That the Indiana University Medical Center be urged by the state medical association to enter into any well-balanced and acceptable plan to provide for a demonstration premature center, giving direct service in this area and providing a training program for nursing personnel and medical students.

This report, the accompanying statements, and the necessary resolutions are hereby respectfully submitted by the Committee on Maternal and Child Health to the House of Delegates of the Indiana State Medical Association for consideration, approval, and action.

G. W. Gustafson, M.D., *Chairman,*
Mahlon F. Miller, M.D.,
Foster J. Hudson, M.D.,
R. A. Craig, M.D.,
Rex W. Dixon, M.D.,
Milo K. Miller, M.D.,
R. R. Hippensteel, M.D.,
H. W. Eggers, M.D.,
Joseph H. Stamper, M.D.,
Frank W. Peyton, M. D.,
Richard S. Bloomer, M.D.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

House of Delegates,
Indiana State Medical Association,

Gentlemen:

No business has been referred to the Liaison Committee of the Division of Services for Crippled Children during the past year. Therefore, this Committee has no report.

M. C. Topping, M.D., *Chairman,*
H. E. English, M.D.,
C. O. Almquist, M.D.,
George Cook, M.D.,
George J. Garceau, M.D.

AUDITING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Auditing Committee met at the Indiana National Bank, Indianapolis, on July 16, 1947, for its annual meeting. Investments of the association were examined and found to be in order in both the General Fund and the Medical Defense Fund.

Five $1,000 United States Treasury bonds in the General Fund have been called since the George S. Olive and Company, certified public accountants, compiled the financial statement of the Indiana State Medical Association for the year ending De-

cember 31, 1946. (See treasurer's report, pages 1015, 1016, and 1017). This $5,000 was reinvested January, 1947, in United States Savings Bonds, Series G. Also, in April, 1947, $5,000 from the General Fund checking account was invested in United States Savings Bonds, Series G. Hence, the investments of the association at this time consist of the following:

General Fund:		
Marion County Flood Prevention bonds	$3,000.00	
Indianapolis City Hospital bonds	5,000.00	
U. S. Treasury bonds	8,000.00	
U. S. Savings bonds, Series G	15,000.00	$31,000.00
Medical Defense Fund:		
Marion County Flood Prevention bonds	$2,000.00	
U. S. Treasury bonds	5,000.00	
U. S. Savings bonds, Series G	5,000.00	
U. S. Baby bonds	3,000.00	15,000.00
Total investments		$46,000.00

Cash balances in The Indiana National Bank, The American National Bank, The Fletcher Trust Company, and The Bankers Trust Company, as shown by the bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and show balances as of June 30, 1947, as follows:

General Fund	$28,740.35
Medical Defense Fund	4,790.73
THE JOURNAL Fund	12,724.07
Petty Cash Fund	202.15
Total	$46,457.30

O. B. NORMAN, M.D., *Chairman,*
CHARLES WISE, M.D.,
R. H. ELLIOTT, M.D.

COMMITTEE ON CONTROL OF CANCER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Two called meetings of this committee were held during the year in connection with meetings of the Indiana Cancer Society. However, the chairman of this committee is one of the vice-presidents of the Indiana Cancer Society and has been in constant contact with the work of that organization. This report will be largely a review of the accomplishments of the Indiana Cancer Society and recommendations for more active participation of the county units of the Indiana State Medical Association.

The officers of the Indiana Cancer Society, elected at the meeting of the board of directors on June 24, 1947, are: William H. Ball, Muncie, president; Harry V. Wade, Indianapolis, executive vice-president; Thurman B. Rice, M.D., Indianapolis, vice-president, Director of Lay and Professional Education; Clyde G. Culbertson, M.D., Indianapolis, vice-president, Director of Research; Chester A. Stayton, M.D., Indianapolis, vice-president, Director of Service; Henry F. Schricker, Indianapolis, treasurer, and Mrs. James H. Cloetingh, South Bend, secretary.

The following members of the Indiana State Medical Association serve on the Board of Directors of the Indiana Cancer Society, Inc.: Drs. John D. VanNuys, Leroy Burney, E. E. Padgett, Don D. Bowers, Chester A. Stayton, Clyde G. Culbertson, Thurman B. Rice, John A MacDonald, of Indianapolis; Stanley A. Clark, A. S. Giordano, Kenneth Olson, of South Bend; Paul J. Bronson, of Terre Haute; S. M. Rabson, of Fort Wayne; C. V. Rozelle, of Anderson, and Mell Welborn, of Evansville.

The Executive Committee of the Indiana State Medical Association, at its meeting on May 25, 1947, took the following action:

1. Approved wholeheartedly the position of the Committee on Control of Cancer of the Indiana State Medical Association and the Executive Committee of the Indiana Cancer Society in the position they assumed in relation to the expenditure of funds in Randolph county, i.e., that no county projects for the expenditure of Indiana Cancer Society funds to physicians or hospitals for the treatment of patients afflicted with malignant disease be approved except in an emergency, the question of the emergency to be determined by the Service Committee of the Indiana Cancer Society.
2. Recommended that a full-time physician be employed as Executive Vice-president of the Indiana Cancer Society.

The survey of cancer needs in Indiana, by Dr. William F. King of the Indiana State Board of Health, and approved by the House of Delegates last year is being carried forward. The lay educational program has been intensified and approximately 875,000 pieces of educational material were distributed. No organized effort on professional education regarding cancer was carried out in this state. No fellowships in pathology or radiology were established during the year. Many county cancer societies carried out approved service programs.

Detection clinics were held at LaFayette, Anderson, Terre Haute, and Rensselaer. Cancer information centers and loan cupboards, "Little Red Doors," are being operated by the following county organizations: South Bend, Evansville, Terre Haute, and Indianapolis.

Campaign for Funds

The campaign for funds carried out in May was participated in by Indiana with Mr. Anton J. Hulman, Jr., of Terre Haute, as state chairman. The goal for Indiana was set by the American Cancer Society at $282,120.00. The total

campaign receipts as of August 20, 1947, were $322,198.69. The cost of the campaign was $17,-238.19 or 5.35 per cent of the money collected. The division of the funds follows the same procedure as in the past, i.e., 40 per cent of the funds raised in each county is returned to that county if there is a suitable service or educational project which has been approved by the county medical society and the state and national offices of the American Cancer Society; 20 per cent of the funds raised are retained by the state office for service projects on a state level and for state office administration, and 40 per cent of the total goes to the American Cancer Society in New York for research, educational and service programs, and the administration of the national office. During the campaign for funds, an appreciation luncheon was given by the Indiana Cancer Society honoring Dr. H. G. Muller of Indiana University, recipient of the 1946 Nobel prize in medicine.

Action Taken at the Annual Meeting of the Indiana Cancer Society, June 24, 1947.

1. *Lay education* should continue to have the emphasis it deserves and should be continued on the present lines which appear to be effective.

2. Professional education should be given more emphasis. The first step considered necessary is a central point from which the professional education may flow. To implement this $6,000 was allocated toward the establishment of a Chair of Oncology at Indiana University School of Medicine, and $4,000 for postgraduate courses at the Medical Center and other strategic points throughout the state.

3. Approval of the employment of a managing director to the Indiana Cancer Society.

4. Approval of the recommendation of the Executive Committee of the Indiana State Medical Association which calls for the employment of a full-time medical director by the Indiana Cancer Society.

5. The designation of eleven medical centers throughout the state where consultation in cancer diagnosis can be obtained, these centers to approximate geographically the State Board of Health's proposed co-ordinated hospital centers for Indiana.

The requirements for these centers would be:

a. One or more hospitals or clinics with complete diagnostic facilities.
b. Approved surgeons, radiologists, pathologists, and other specialists for each hospital or clinic.
c. Hospital staff societies willing to organize Cancer Diagnostic Clinics as outlined by the American College of Surgeons.
d. Willingness on the part of the local medical society to approve such a program.

6. Establishment of a division of cancer control in the Indiana State Board of Health.

7. The appointment of a medical and scientific committee to the Indiana Cancer Society, Inc.

8. Continuation of the cancer follow-up service at the Indiana University and City Hospital tumor clinics, appropriation $4,800.

A letter from the Chief of the National Cancer Institute at Bethesda, Maryland, dated July 15, 1947, states: "It is my understanding that the Indiana State Board of Health plans in the near future to establish a Cancer Control Division. Such proposed action should be desirable in bringing about the necessary integration on a state-wide basis of the Cancer Society, Health Department, and State Medical Association. The fund available to the Indiana State Board of Health for this fiscal year under the formula basis is $58,563, to be allotted following the submittal of an acceptable plan and budget."

This year in Indiana there will be approximately $251,763 specifically earmarked for cancer control activities. Of this, $58,563 may be spent under the direction of the State Board of Health on suitable projects and administration having to do with cancer control. The Indiana Cancer Society has $128,800 on the county level and $64,400 on the state level which may be spent for suitable projects and administration. An unknown sum of money will be allocated for research problems in Indiana by the National Research Council. There seems to be no limit to the amount of funds that can be raised if there are suitable projects to combat this disease which is responsible for the second greatest number of deaths. The lay public is earnestly aroused and militant in its endeavor to improve educational, diagnostic, treatment, and advanced care facilities for the public.

Acceptable County Projects (if approved by the county medical society)

$50 to $150:
1. Transportation fund.
2. Loan cupboard.
3. Poster contest.
4. Essay contest.

$150 to $500:
1. Working fund for the use of needy cancer patients upon the recommendation of a physician.
2. Educational program.
3. Biopsy fund for needy patients.
 a. Surgical procurement $10.00
 b. Pathological study and report ... $ 5.00

$500 to $10,000:
1. The purchase of equipment to be used in the diagnosis and treatment of cancer for public hospitals.
2. Scholarships for x-ray and laboratory technicians.
3. Information and detection centers, diagnostic and treatment clinics, and administration.
4. Permanent office and administration expense.

Recommendations

1. Each county medical society to maintain an active cancer control committee.

2. Emphasis on a spirit of leadership and active co-operation with county cancer societies.

3. That the cancer teaching program to undergraduates in medical and dental school be given greater emphasis in order to utilize federal funds available for that purpose.

4. That funds collected by the Indiana Cancer Society be expended for education, service to the patient, and research.

5. That no funds be paid to physicians or hospitals for the treatment of individual patients except in an emergency to be determined by the service committee of the Indiana Cancer Society.

C. A. Stayton, Sr., M.D., *Chairman*,
A. T. Jones, M.D.,
Henry O. Mertz, M.D.,
J. J. Connelly, M.D.

COMMITTEE ON VENEREAL DISEASE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

As nothing of sufficient importance has come to the attention of this committee during the past year to warrant the calling of a meeting, the committee has no report to make at this time.

F. R. N. Carter, M.D., *Chairman*,
W. W. Hewins, M.D.,
E. O. Nay, M.D.,
Ernest Rupel, M.D.,
T. R. Hayes, M.D.,
Louis Sandoz, M.D.,
W. C. McCormick, M.D.,
Don Kelly, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

In keeping with its previously established objective to promote postgraduate and undergraduate training in industrial medicine, the committee sponsored its third postgraduate conference on industrial medicine at the medical school on April 16, 1947. Nationally known speakers made up the program and this meeting was, by far, the finest we have had. The attendance showed representation from the entire state. The numerical number present was rather small, although significantly higher than for corresponding meetings in other states. The men attending were primarily industrial physicians, whereas it was our hope that more general practitioners would avail themselves of such courses.

Following the belief that we are not reaching the men we want to, the committee held a meeting following this conference and, after due deliberation of the problem, came to the unanimous conclusion that the best single place to contact the general practitioner is at the state medical meeting. The general practitioner is the most important person in industrial medicine, for he does better than 80 per cent of the industrial medicine done in Indiana. This is due to the fact that out of the 4,000 plants located in this state 92 per cent employ less than 500 people. Thus the plants are too small to employ full-time medical men and consequently get part-time medical coverage. Indiana is now the eighth largest industrial state in the union and somehow or other must cope with the industrial medical problem.

Thus, due to the fact that industrial medicine is done on a part-time basis, that it is fast becoming an important phase of the practice of medicine, that innumerable new occupational diseases are occuring yearly, the committee felt that medical societies should take the lead and train men for such services to industry and also to be aware of such diseases as part of their practice. Based on previous experience, the conference method did not achieve this end. It is our unanimous opinion that this could be accomplished through the creation of a section on occupational medicine in the state medical association.

Through this technique prominent speakers could be obtained, the section would serve the full-time and part-time industrial medical men and also be available to general practitioners. This would be a strong forward step by our association for, to the best of our knowledge, no other state society has such a section. There is precedent for such thinking in that the American Medical Association has a Council on Industrial Health. Thus it is our recommendation to the association that such a section be created.

To develop further the educational phase of our program, we have asked all district and county societies to have at least one program on occupational medicine. The response has been very gratifying and encouraging. Further, our recommendation to the medical school, that an undergraduate course on Industrial Medicine be given, has been acted on and such a course has been instituted and given for the first time this year.

Some hospitals have had at least one staff meeting devoted to problems of occupational medicine. These were extremely educational and brought forth a great deal of favorable comment.

I want to take this opportunity of thanking the committee and the officers of the state association for their very fine co-operation and excellent publicity given our April meeting.

E. S. Jones, M.D., *Chairman*,
H. M. Trusler, M.D.,
John Hilbert, M.D.,
L. W. Spolyar, M.D.,
W. R. Glock, M.D.,
E. B. Mumford, M.D.,
C. A. Weller, M.D.,
E. T. Stahl, M.D.,
F. M. Whisler, M.D.,
M. R. Davis, M.D.,
E. H. Carlton, M.D.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Indiana Inter-Professional Health Council met in October and December, 1946, and in each meeting the discussion was devoted principally to proposed legislation coming before the 1947 Indiana General Assembly.

At the October meeting Dr. L. E. Burney, state health commissioner, outlined the program of the State Board of Health, which included bills the board would sponsor in the General Assembly. Plans being projected by the Council for Mental Health for better care of the state's mentally ill, which embraced its legislative program, were outlined by Dr. Norman M. Beatty, chairman, and Dr. C. L. Williams, who was then its director.

Voluntary health insurance in contrast to compulsory health insurance was reviewed by Dr. N. K. Forster, who was chairman of the Council on Medical Service and Public Relations of the Indiana State Medical Association at that time.

Representatives of other groups discussed legislation they were going to propose to the General Assembly.

Dean Glenn L. Jenkins of Purdue University School of Pharmacy was re-elected chairman. Other officers, all re-elected, were E. E. Ewbank, D.D.S., secretary of the Indiana State Dental Association, vice-chairman, and Henry W. Heine, secretary-treasurer.

The medical profession was represented at this meeting by Doctors Beatty, Burney, Forster, Williams, J. E. Ferrell, A. P. Hauss, Thurman B. Rice, and Mr. Ray E. Smith.

It was announced at the December meeting that Dr. Beatty had been elected chairman of the executive committee of the Council. This committee submitted a report to the Council on conferences with the Governor regarding proposed legislation.

Timely suggestions on legislative procedure were presented by Albert Stump, counsel of the Indiana State Medical Association.

Physicians at this meeting included Drs. A. P. Hauss and L. E. Burney.

E. H. Clauser, M.D., *Chairman,*
A. P. Hauss, M.D.,
Floyd T. Romberger, M.D.,
Alfred Ellison, M.D.,
Norman M. Beatty, M.D.

ANTI-TUBERCULOSIS COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Anti-Tuberculosis Committee of the Indiana State Medical Association held a luncheon meeting on October 30, 1946, at the Murat Temple, Indianapolis, during the annual session of the association. The meeting was attended by seventy-five members of the state and county anti-tuberculosis committees. Dr. Harold C. Ochsner of Indianapolis gave a report on routine photofluorographic chest examinations of 2,500 cases in the Methodist Hospital of Indianapolis, which showed the value of x-ray in routine hospital admissions. Discussion was led by Drs. Raymond C. Beeler, Indianapolis; M. H. Draper, Fort Wayne; and E. W. Custer, South Bend; followed by general discussion, and an x-ray conference sponsored by the Indiana Chapter of the American College of Chest Physicians.

The committee met again on Sunday, July 20, 1947, at the Columbia Club, Indianapolis. Those present were: Drs. Philip H. Becker, Crown Point; H. W. Garton, Fort Wayne; J. V. Pace, New Albany; Merle Bundy, Indianapolis, director of Tuberculosis Control of the State Board of Health; and J. H. Stygall, Indianapolis. In addition, twenty-five members of the Indiana Chapter of the American College of Chest Physicians attended the meeting. Several of the state and county sanatoria showed serial films visualizing the results of streptomycin therapy. A general discussion followed. The consensus was that streptomycin has a definite place in the treatment of tuberculosis.

The chairman reported on the meeting of the National Council of Tuberculosis Committees held at Atlantic City in June during the annual session of the American Medical Association, at which time it was suggested that x-ray exhibits, demonstrating different methods of treating tuberculosis by the state sanatoria and possibly some of the county sanatoria at the annual sessions of some of the state societies had been successful in other states. The committee approved of having such an exhibit at the annual session of the Indiana State Medical Association and the chairman of the Scientific Exhibit Committee is to be contacted and arrangements made for such an exhibit.

In view of the fact that a Section on Diseases of the Chest in the American Medical Association was approved at the annual session of the A.M.A. at Atlantic City in June, the Anti-Tuberculosis Committee and the Indiana Chapter of the American College of Chest Physicians voted unanimously to petition the House of Delegates of the Indiana State Medical Association for permission to create a Section on Diseases of the Chest. We therefore present the following resolution for consideration of the House:

Whereas The members of the Anti-Tuberculosis Committee of the Indiana State Medical

Association and the Indiana Chapter of the American College of Chest Physicians met on July 20, 1947, and were unanimous in their belief that a Section on Diseases of the Chest would be beneficial to both the public and the medical profession at large,

Be It Resolved, That the House of Delegates of the Indiana State Medical Association grant to us, the members of the Anti-Tuberculosis Committee of the state association, the privilege of organizing a Section on Diseases of the Chest wherein we may meet to discuss the social and economic features relating to and wherein we may present scientific data pertinent to the specialty of tuberculosis and diseases of the chest, and

Be It Further Resolved, That the following amendment be made to the present By-Laws of the state association, to-wit:

"Chapter III of the By-Laws, entitled 'Sections' to read as follows:

"Section 1. During the Annual Session, the Association may meet in the following sections:

a. Surgical.
b. Medical.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. Diseases of the Chest.
f. Any other sections that hereafter may be provided for by the House of Delegates."

Jas. H. Stygall, M.D., *Chairman*,
Philip H. Becker, M.D.,
L. C. Marshall, M.D.,
H. W. Garton, M.D.,
J. V. Pace, M.D.

COMMITTEE ON CONSERVATION OF VISION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Conservation of Vision was responsible for the subject matter of the May issue of The Journal, which contained informative articles on conservation of vision, including the study and problems presented by strabismus, the role of the contact lens, ophthalmology in industry, and other topics of interest not only to ophthalmologists, but to the general practitioner, as well.

It has been decided to hold a breakfast meeting on Conservation of Vision at the time of the state meeting at French Lick, to which all members of the state and county conservation of vision committees are cordially invited. The meeting will be held at 7:30 A.M., Wednesday, October 29, 1947. The committee feels very fortunate in securing a speaker so ably qualified as Hedwig S. Kuhn, M.D., Hammond, for this occasion.

Eugene L. Bulson, M.D., *Chairman*,
Howard E. Hill, M.D.,
C. W. Rutherford, M.D.,
H. Brooks Smith, M.D.,
Richard P. Good, M.D.

MEDICAL RELIEF COMMITTEE

(No report submitted.)

COMMITTEE ON RURAL MEDICAL CARE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Rural Medical Care Committee of the Indiana State Medical Assocation held two committee meetings.

At the first meeting the following organizations were represented: Indiana State Board of Health, Indiana Farm Bureau, Indiana Grange, American Medical Association, and the Blue Cross Hospitalization Insurance Company.

It was stated that Dean Reed of Purdue University felt that there was need of a full time man to work with the County Health Committees, as they had no idea of what their objective might be.

Dr. Burney suggested that we enlarge our State Committee. The group suggested organizations that they thought should be included. Mr. Ray Smith contacted these groups to meet with the Committee on June first.

At the second meeting the following organizations were represented: The Farm Bureau, State Grange, American Medical Association, Committee on Rural Medical Service, State Board of Health, Indiana Economic Council, Indiana University, and Indiana State Medical Association.

On Dr. Crockett's motion and seconded by the Reverend Mr. Graham of the Grange, it was voted to establish a health council on the state level, also to appoint a committee of five to select the organizations to be represented on the council, and to ask the Governor whether he would name the council.

The committee appointed was Dr. Crockett, chairman, with the Reverend Mr. Graham of the Grange, Mrs. Flinn of the Farm Bureau, Mr. Schellie of the Indiana Economic Council, and Dr. Burney of the State Board of Health, as committee members.

The committee was asked to set a definite goal toward which to work.

H. N. Smith, M.D., *Chairman*,
I. H. Scott, M.D.,
George A. May, M.D.,
George V. Cring, M.D.,
George L. Derhammer, M.D.

COMMITTEE ON HARD OF HEARING

House of Delegates,
Indiana State Medical Association.

Gentlemen:

There has been no specific activity this year of the Committee on Hard of Hearing.

J. Kent Leasure, M.D., *Chairman*,
O. T. Allen, M.D.,
E. E. Holland, M.D.,
B. D. Ravdin, M.D.,
H. C. Parker, M.D.

COMMITTEE ON REHABILITATION SERVICES

House of Delegates,
Indiana State Medical Association.

Gentlemen:

During the current year there has been little demand for rehabilitation work, as the veterans seemed to be able to find suitable locations quite readily.

This committee is widely scattered over the state and there has been no official meeting. There has been some assistance given in individual cases, but no official committee action has been taken.

BERT E. ELLIS, M.D., *Chairman,*
RAY ELLEDGE, M.D.,
ROBERT B. ACKER, M.D.,
KEITH T. MEYER, M.D.,
RICHARD L. HANE, M.D.

COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

This committee was created by the Council last January to administer the awarding of six scholarships to medical school students. At a meeting March 2, 1947, a "Declaration of Trust" was adopted by the committee for the purpose of receiving and dispensing funds and to establish conditions under which the scholarships would be given.

A booklet explaining the scholarships and containing the "Declaration of Trust" was printed and mailed to deans of nineteen Indiana colleges whose premedic credits are acceptable by the Indiana University School of Medicine. Forms for making application for a scholarship and for the committee to use in contacting the individuals named as references were also printed and distributed.

Meantime, the Council at its meeting July 20, 1947, voted six scholarships for nursing school students and assigned this committee the task of administering these awards. This necessitated amending the "Declaration of Trust" to include the new scholarships and changing the name of the committee to "Committee on Medical and Nursing School Scholarships."

The directors of nurses of the twenty-seven accredited Indiana hospital nursing schools were advised of the scholarships, and application forms were sent them to distribute. The committee will meet to act upon applications after August 30, 1947, the deadline for submission of applications for the current school year.

Medical school scholarships were awarded August 10, 1947, to four young men. They are:

Herbert C. Ashmore, Lafayette, freshman.
Earl R. Leinbach, Goshen, freshman.
Fred W. Dierdorf, Terre Haute, sophomore.
Carl H. Ault, Indianapolis, sophomore.

The Council voted $3,000 annually for the medical school scholarships and $1,200 a year for the nursing school awards. It is hoped that philanthropic individuals and business organizations will augment these sums with donations so that more scholarships can be provided. The committee has received word that the wills of one childless couple set up trusts, the income of which will go to the medical scholarship fund.

Recipients of medical scholarships agree to practice medicine for a period of five years in some Indiana community needing a doctor. By doing so they fulfill the obligations under which they accepted the scholarship. If they do not wish to practice in a specified area, they may refund the money and be relieved of their contract. Through the scholarships the Council hopes to alleviate to a degree the need for physicians in rural towns.

The committee recommends to the Council that money placed in the trust fund, if not expended for scholarships in the year for which it was appropriated, be carried over from year to year so it will be available for use by the committee.

The intent of the nursing school scholarships is to make it possible for girls without financial resources to become nurses. The shortage of nurses, now critical, is expected to become more so as new hospitals are constructed in Indiana under the Hill-Burton Act.

The committee has had opportunity to appraise the scholarship program inaugurated by the Council and is convinced that it is sound; that it is meeting with public acceptance, and that a genuine contribution is being made to rural medical care and the education of more girls to do nursing.

C. J. CLARK, M.D., *Chairman,*
N. K. FORSTER, M.D.,
M. R. LOHMAN, M.D.,
HERMAN T. COMBS, M.D.

Ex-officio members:
FLOYD T. ROMBERGER, M.D.,
President;
ALFRED ELLISON, M.D.,
Chairman of Council;
NORMAN M. BEATTY, M.D.,
J. WILLIAM WRIGHT, M.D.,
Co-chairmen,
Legislative Committee.

CENTENNIAL CELEBRATION COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

During the past year the energies of the committee have been applied to the preparation of the Memorial Book and considerable progress has been made in accumulating the manuscripts for the different chapters. In addition to the history of the association itself, there will be the story of Medical Education written by Dr. B. D. Myers, the history

of the State Board of Health by Dr. Thurman B. Rice, and the chapter on Pioneer Medicine by Mrs. Dorothy Russo.

Other chapters in the process of preparation include the History of Nursing by Miss Dotaline Allen of the Indiana University School of Nursing Education, the History of Pharmacy by Dean G. L. Jenkins of the Purdue School of Pharmacy, the story of our own State Journal and other medical publications by Dr. E. M. Shanklin, and a History of the State Board of Medical Registration and Examination by Miss Ruth Kirk, the Executive Secretary of that Board. We are still undecided about the history of dentistry and of the growth of hospitals, and will welcome suggestions. We are securing a speaker for the 1949 banquet who is renowned in the field of medico-historical research.

The actual date of the founding of our association was June 6, 1849, and the Committee discussed at length the idea of holding the 1949 session during the week of June 6.

We were impelled to do it for sentimental reasons, but for practical reasons we considered it inadvisable, and we therefore refer the question to the House of Delegates for disposition.

Pending that decision, which should be made at once, Mr. Ray Smith has secured an option on the June week from the Indianapolis Convention Bureau. We agreed unanimously, of course, that the place of the meeting should be the birthplace, Indianapolis.

Charles N. Combs, M.D., *Chairman,*
Edgar F. Kiser, M.D.,
L. G. Zerfas, M.D.,
F. A. Malmstone, M.D.,
V. L. Turley, M.D.,
O. B. Nesbit, M.D.,
G. Irene Polhemus, M.D.,
J. B. Maple, M.D.,
W. N. Wishard, Jr., M.D.,
John Iddings, M.D.,
Margaret Owen, M.D.

VETERANS COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Subsequent to the agreement for rendering medical care to Veterans, entered into by the Indiana State Medical Association with the Veterans Administration under date of August 1, 1946, the following amendments to such agreement have been accepted by the Council of the Indiana State Medical Association and executed by the Veterans Committee:

(1) The agreement shall be effective for the period of August 1, 1946, to June 30, 1947, and be renewed for a period of one year by written request sixty days prior to termination date and accepted thirty days prior to same date.

(2) Examinations of veterans for the purpose of disability rating for service connected disabilities shall be done by physicians selected by the Veterans Administration and not by choice of the veteran.

Under date of May 10, 1947, and by approval of the Council, a Revised Fee Schedule for services rendered to veterans was submitted to the component county societies for their approval. Such Fee Schedule was a revision of that which was a part of the original agreement. The purpose of revision was to obtain uniformity of fees for medical services to veterans in the thirty-eight states in which there were agreements for care to veterans. The Revised Fee Schedule was not at an appreciable variance with the original one by overall comparison and was, accordingly, accepted by the state association following approval of county societies on June 15, 1947, effective July 1, 1947.

The volume of medical care to veterans by physicians in Indiana in their respective communities during the past nine months is indicated by the following:

From a total of 1,400 fee-designated physicians in Indiana, the services of 700 were used. Approximately 4,500 examinations and 4,500 treatments were rendered each month.

Charles F. Thompson, M.D., *Chairman,*
Will W. Washburn, M.D.,
William H. Garner, M.D.,
Glen W. Lee, M.D.,
Dudley A. Pfaff, M.D.,
Harold F. Zwick, M.D.

COMMITTEE ON STATE FAIR

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The exhibit of the Committee on State Fair at the 1947 Indiana State Fair was located in the Education Building. Through the co-operation of the Committee on Scientific Exhibit of the American Medical Association two very interesting and informative exhibits covering "Heart Disease" and "Hay Fever" were made available to the fair-going public. The popular "Medical Question Box" also was supplied by the American Medical Association. The increasingly popular "Blood Pressure Determination" table, with two operating positions, attracted much interest again this year. More than five thousand blood pressures were taken and recorded by the three medical student exhibit assistants. Each abnormal person was given a note to

take to his family physician for further advice and treatment. A large number of MOTHER GOOSE FAIRY TALE booklets covering certain cautions concerning medicine and illnesses, bearing the general theme of "see your family physician first," were distributed.

Again this year, as in the past, the committee is indebted to Mr. Ray E. Smith, executive secretary of the Indiana State Medical Association, and Mr. Bert Baldwin, display technician of the Indiana State Board of Health, for their excellent co-operation in making our exhibit a success.

R. H. WISEHEART, M.D., *Chairman*,
R. V. PEARCE, M.D.,
M. B. FERRELL, M.D.,
H. W. BEAVER, M.D.,
LOREN MARTIN, M.D.,
J. L. SIMS, M.D.,
C. G. KERN, M.D.,
D. J. STEELE, M.D.

AMENDMENT TO CONSTITUTION TO BE VOTED ON AT THE FRENCH LICK SESSION

At the 1946 annual session in Indianapolis the House of Delegates voted to delete Section 4 of Article IX of the Constitution, which reads as follows:

"*Sec. 4.* The Councilors shall be elected by the respective district societies, providing that if any district shall exist without a society, or if the district society fails to meet and elect its Councilor and notify the House of Delegates before or at the time of the Annual Session, the Councilor for such a district shall be elected by the House of Delegates. Provided further, That if a Councilor district society fails to meet and elect its Councilor, the Councilor for that district shall be elected by the House of Delegates."

and to replace this by a new Section 4, which reads as follows:

"*Sec. 4.* The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

This amendment was printed in the December, 1946, JOURNAL and is reprinted here to conform with Article XIV of the Constitution which states that "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published twice during the year in THE JOURNAL of this Association."

REFERENCE COMMITTEES — 1947

1. Sections and Section Work:
Chairman, C. S. Black, Warren (Huntington)
Foster J. Hudson, Indianapolis (Marion)
R. R. Calvert, Lafayette (Tippecanoe)
Gerald S. Young, Muncie (Delaware-Blackford)
Charles E. Gillespie, Seymour (Jackson)

2. Rules and Order of Business:
Chairman, M. B. Catlett, Fort Wayne (Allen)
E. B. Jewell, Logansport (Cass)
S. M. Cotton, Goldsmith (Tipton)
N. A. James, Tell City (Perry)
John C. Glackman, Jr., Rockport (Spencer)

3. Medical Education and Hospitals:
Chairman, Herman M. Baker, Evansville (Vanderburgh)
Roy A. Geider, Indianapolis (Marion)
F. R. N. Carter, South Bend (St. Joseph)
Robert M. Dearmin, Indianapolis (Marion)
C. V. Rozelle, Anderson (Madison)

4. Public Policy and Legislation:
Chairman, E. Vernon Hahn, Indianapolis (Marion)
Will A. Thompson, Liberty (Wayne-Union)
J. R. Doty, Gary (Lake)
J. Frank Maurer, Brazil (Clay)
Claude D. Holmes, Frankfort (Clinton)

5. Publicity:
Chairman, Bert E. Ellis, Indianapolis (Marion)
Lee Maris, Attica (Fountain-Warren)
Irvin E. Huckleberry, Salem (Washington)
Harry P. Ross, Richmond (Wayne-Union)
E. E. Padgett, Indianapolis (Marion)

6. Hygiene and Public Health:
Chairman, William H. Garner, New Albany (Floyd)
Truman E. Caylor, Bluffton (Wells)
M. C. Topping, Terre Haute (Vigo)
Paul D. Crimm, Evansville (Vanderburgh)
J. K. Jackson, Aurora (Dearborn-Ohio)

7. Amendments to Constitution and By-Laws:
Chairman, Gordon A. Thomas, Lafayette (Tippecanoe)
B. F. Pence, Columbia City (Whitley)
G. L. Verplank, Gary (Lake)
E. O. Nay, Terre Haute (Vigo)
Dan E. Talbott, Indianapolis (Marion)

8. Reports of Officers:
Chairman, A. C. Yoder, Goshen (Elkhart)
J. E. Ferrell, Fortville (Hancock)
Claude Dollens, Oolitic (Lawrence)
C. F. Briggs, Sullivan (Sullivan)
Joseph E. Dudding, Hope (Bartholomew-Brown)

9. Committee on Credentials:
Chairman, John S. Hash, Noblesville (Hamilton)
William Karsell, Bloomington (Owen-Monroe)
Joseph R. Bloomer, Rockville (Parke-Vermillion)
Richard Schantz, Remington (Jasper-Newton)
A. A. Wade, Howe (LaGrange)

10. Committee on Miscellaneous Business:
Chairman, Jacob T. Oliphant, Farmersburg (Sullivan)
Charles O. Weddle, Lebanon (Boone)
E. P. Buckley, Jeffersonville (Clark)
Albert M. DeArmond, Indianapolis (Marion)
J. M. Kirtley, Crawfordsville (Montgomery)

HOUSE OF DELEGATES, INDIANA STATE MEDICAL ASSOCIATION

FRENCH LICK, INDIANA

October 28, 29, and 30, 1947

Delegates	Alternates
ADAMS	
Ben Duke, Decatur	James Burk, Decatur
ALLEN	
M. B. Catlett, Fort Wayne	C. B. Parker, Fort Wayne
Arnold H. Duemling, Fort Wayne	Vaughn Scott, Fort Wayne
Milton Popp, Fort Wayne	William Clark, Fort Wayne
Maurice Glock, Fort Wayne	A. J. Roser, Fort Wayne
BARTHOLOMEW-BROWN	
Joseph E. Dudding, Hope	Lowell F. Beggs, Columbus
BENTON	
V. L. Turley, Fowler	W. H. Altier, Fowler
BOONE	
Charles O. Weddle, Lebanon	C. G. Kern, Lebanon
CARROLL	
C. L. Wise, Camden	J. R. McLaughlin, Flora
CASS	
E. B. Jewell, Logansport	John C. Davis, Logansport
CLARK	
E. P. Buckley, Jeffersonville	Samuel Adair, Jeffersonville
CLAY	
J. Frank Maurer, Brazil	Opal L. Wood, Brazil
CLINTON	
C. D. Holmes, Frankfort	Frank Beardsley, Frankfort
CRAWFORD	
DAVIESS-MARTIN	
A. G. Blazey, Washington	C. P. Fox, Washington
E. B. Lett, Loogootee	E. E. Eifert, Loogootee
DEARBORN-OHIO	
J. K. Jackson, Aurora	O. H. Stewart, Aurora
G. S. Fessler, Rising Sun	C. N. Manley, Rising Sun
DECATUR	
Boyd Mahuron, Greensburg	H. S. McKee, Greensburg
DEKALB	
C. B. Hathaway, Butler	R. P. Reynolds, Garrett
DELAWARE-BLACKFORD	
Gerald S. Young, Muncie	Clay A. Ball, Muncie
Orville A. Hall, Muncie	N. Kemper Venis, Muncie
DUBOIS	
F. P. Williams, Huntingburg	G. A. Held, Jasper
ELKHART	
A. C. Yoder, Goshen	A. A. Norris, Elkhart
S. T. Miller, Elkhart	A. W. Hull, Elkhart
FAYETTE-FRANKLIN	
Francis Mountain, Connersville	A. F. Gregg, Connersville
H. N. Smith, Brookville	E. M. Glaser, Brookville
FLOYD	
William H. Garner, New Albany	
FOUNTAIN-WARREN	
Lee Maris, Attica	
Lowell Stephens, Covington	
FULTON	
E. V. Herendeen, Rochester	Virgil C. Miller, Akron
GIBSON	
Carl Clark, Oakland City	
GRANT	
Russell W. Lavengood, Marion	L. D. Holliday, Fairmount
GREENE	
Wm. F. Craft, Linton	John W. Woner, Linton
HAMILTON	
John S. Hash, Noblesville	C. M. Donahue, Carmel

Delegates	Alternates
HANCOCK	
Joseph L. Allen, Greenfield	Lawrence B. Rariden, Greenfield
HARRISON	
William E. Amy, Corydon	L. F. Glenn, Ramsey
HENDRICKS	
O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
HENRY	
Walter M. Stout, New Castle	L. C. Marshall, Mt. Summit
HOWARD	
HUNTINGTON	
G. M. Nie, Huntington	J. R. Ware, Huntington
JACKSON	
G. R. Gillespie, Brownstown	L. W. Elsner, Seymour
JASPER-NEWTON	
Richard Schantz, Remintgon	Ernest Beaver, Rensselaer
W. G. Pippenger, Brook	R. H. Ruhmkorff, Goodland
JAY	
George V. Cring, Portland	
JEFFERSON	
Jack Modisett, Madison	George A. May, Madison
JENNINGS	
D. W. Matthews, North Vernon	W. L. Grossman, North Vernon
JOHNSON	
O. A. Province, Franklin	W. L. Portteus, Franklin
KNOX	
Virgil C. McMahan, Vincennes	Frederic Spencer, Vincennes
KOSCIUSKO	
Dan Urschel, Mentone	H. A. P. Leininger, Warsaw
LA GRANGE	
A. A. Wade, Howe	Harry Erwin, LaGrange
LAKE	
Ray Elledge, Hammond	S. J. Petronella, East Chicago
H. W. Eggers, Hammond	F. H. Mervis, East Chicago
J. R. Doty, Gary	J. P. Vye, Gary
C. M. Jones, Whiting	E. L. Schaible, Gary
G. L. Verplank, Gary	F. J. McMichael, Gary
LAPORTE	
Jon Kelly, LaPorte	Francis Kubik, Michigan City
LAWRENCE	
Claude Dollens, Oolitic	R. B. Smallwood, Bedford
MADISON	
A. T. Jones, Pendleton	S. W. Ellis, Anderson
C. V. Rozelle, Anderson	H. W. Gante, Anderson
MARION	
Marlow W. Manion, Indianapolis	
Bert E. Ellis, Indianapolis	
Foster J. Hudson, Indianapolis	
James F. Balch, Indianapolis	
Charles F. Thompson, Indianapolis	
Clyde G. Culbertson, Indianapolis	
Roy A. Geider, Indianapolis	
E. Vernon Hahn, Indianapolis	
Dudley A. Pfaff, Indianapolis	
Frank B. Ramsey, Indianapolis	
Albert M. DeArmond, Indianapolis	
Robert M. Dearmin, Indianapolis	
Harry E. Kitterman, Indianapolis	
William N. Wishard, Jr., Indianapolis	
Dan E. Talbott, Indianapolis	
Harry R. Kerr, Indianapolis	

Delegates	Alternates
MARSHALL	
A. A. Thompson, Tyner	T. R. Possolt, Plymouth
MIAMI	
Fred Malott, Converse	
MONTGOMERY	
J. M. Kirtley, Crawfordsville	W. M. Taylor, Crawfordsville
MORGAN	
R. W. Van Bokkelen, Mooresville	L. M. Hughes, Paragon
NOBLE	
C. E. Munk, Kendallville	Q. F. Stultz, Ligonier
ORANGE	
C. E. Boyd, West Baden	John Spears, Paoli
OWEN-MONROE	
M. S. Brown, Spencer	Julia Thom, Spencer
William Karsell, Bloomington	Naomi Dalton, Bloomington
PARKE-VERMILLION	
Joseph R. Bloomer, Rockville	C. Harstad, Rockville
W. C. Myers, Dana	A. F. Cohn, Clinton
PERRY	
N. A. James, Tell City	
PIKE	
L. R. Miller, Winslow	G. B. DeTar, Winslow
PORTER	
John R. Frank, Valparaiso	W. C. Butman, Hebron
POSEY	
A. L. Woods, Poseyville	J. R. Ranes, Mt. Vernon
PULASKI	
William R. Thompson, Winamac	George H. McCaskey, Winamac
PUTNAM	
F. R. Dettloff, Greencastle	J. B. Johnson, Greencastle
RANDOLPH	
J. S. Robison, Winchester	L. E. Jordan, Lynn
RIPLEY	
L. H. Hopkins, Versailles	W. C. McConnell, Sunman
RUSH	
Melvin Denny, Rushville	C. C. Atkins, Rushville
ST. JOSEPH	
Erwin Blackburn, South Bend	R. W. Holdeman, South Bend
A. S. Giordano, South Bend	Josephine Murphy, South Bend
F. R. N. Carter, South Bend	J. V. Cassady, South Bend
SCOTT	
Carl R. Bogardus, Austin	Floyd S. Napper, Scottsburg
SHELBY	
Roger Whitcomb, Shelbyville	V. B. Scott, Shelbyville
SPENCER	
John C. Glackman, Jr., Rockport	John Barrow, Dale
STARKE	
STEUBEN	
Robert D. Barton, Angola	M. M. Crum, Angola
SULLIVAN	
C. F. Briggs, Sullivan	C. E. Whipps, Carlisle
SWITZERLAND	
L. H. Bear, Vevay	R. O. Zink, Vevay
TIPPECANOE	
Gordon A. Thomas, Lafayette	W. W. Washburn, Lafayette
R. R. Calvert, Lafayette	
TIPTON	
S. M. Cotton, Goldsmith	H. G. Warne, Tipton
VANDERBURGH	
Paul D. Crimm, Evansville	
Minor Miller, Evansville	
C. C. Herzer, Evansville	
VIGO	
M. C. Topping, Terre Haute	A. W. Cavins, Terre Haute
E. O. Nay, Terre Haute	W. C. Kunkler, Terre Haute
WABASH	
O. G. Brubaker, North Manchester	G. W. Seward, North Manchester
WARRICK	
P. B. Hoover, Boonville	W. C. Stover, Boonville
WASHINGTON	
Irvin E. Huckleberry, Salem	Lawrence W. Paynter, Salem
WAYNE-UNION	
Will A. Thompson, Liberty	James F. Lewis, Liberty
Harry Ross, Richmond	E. E. Holland, Richmond
WELLS	
Truman E. Caylor, Bluffton	Thomas O. Dorrance, Bluffton
WHITE	
H. W. Greist, Monticello	H. B. Gable, Monticello
WHITLEY	
B. F. Pence, Columbia City	O. F. Lehmberg, Columbia City

DATA FROM PREVIOUS SESSIONS

Year	Session	Place	Registration	Year	Session	Place	Registration
1908	59th	French Lick	312	1928	79th	Gary	892
1909	60th	Terre Haute	421	1929	80th	Evansville	814
1910	61st	Fort Wayne	450	1930	81st	Fort Wayne	1,115
1911	62nd	Indianapolis	748	1931	82nd	Indianapolis	1,033
1912	63rd	Indianapolis	590	1932	83rd	Michigan City	904
1913	64th	West Baden	312	1933	84th	French Lick	637
1914	65th	Lafayette	527	1934	85th	Indianapolis	1,814
1915	66th	Indianapolis	646	1935	86th	Gary	1,011
1916	67th	Fort Wayne	381	1936	87th	South Bend	1,150
1917	68th	Evansville	270	1937	88th	French Lick	1,154
1918	69th	Indianapolis	388	1938	89th	Indianapolis	1,751
1919	70th	Indianapolis	---	1939	90th	Fort Wayne	1,332
1920	71st	South Bend	421	1940	91st	French Lick	1,064
1921	72nd	Indianapolis	550	1941	92nd	Indianapolis	1,890
1922	73rd	Muncie	522	1942	93rd	French Lick	706
1923	74th	Terre Haute	823	1943	94th	Indianapolis	1,323
1924	75th	Indianapolis	1,012	1944	95th	Indianapolis	1,584
1925	76th	Marion	800	1945	96th	French Lick	922
1926	77th	West Baden	900	1946	97th	Indianapolis	2,240
1927	78th	Indianapolis	1,500				

LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served
Medical Convention		
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Fort Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibbard, Richmond	1862	1863
*John Sloan, New Albany	1863	1864
*John Moffett (acting), Rushville	1864	1864
*Samuel M. Linton, Columbus	1864	1865
*Wilson Lockhart (acting), Danville	1865	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert M. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Fort Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselbery, Evansville	1873	----
*Wilson Hobbs, Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.-p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Munford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Fort Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William N. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Fort Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Fort Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
Medical Association		
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Winn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
E. M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
Alois B. Graham, Indianapolis	1929	1931
Franklin Smith Crockett, Lafayette	1930	1932
Joseph H. Weinstein, Terre Haute	1931	1933
Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund Dougan Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
Edmund M. Van Buskirk, Fort Wayne	1937	1939
Karl R. Ruddel, Indianapolis	1938	1940
Albert M. Mitchell, Terre Haute	1939	1941
M. A. Austin, Anderson	1940	1942
C. H. McCaskey, Indianapolis	1941	1943
J. T. Oliphant, Farmersburg	1942	1944
N. K. Forster, Hammond	1943	1945
J. E. Ferrell, Fortville	1944	1946
F. T. Romberger, Lafayette	1945	1947

*Deceased.

EXHIBITORS

Booth Number	
1	RICKRICH SURGICAL SUPPLY CO., Evansville, Ind.
2	H. J. HEINZ COMPANY, Pittsburgh, Pa.
3	AMES COMPANY, INC., Elkhart, Ind.
4	CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N. J.
5	PARKE, DAVIS & COMPANY, Detroit, Mich.
6	CURTIS AND FRENCH, Indianapolis, Ind.
7	ELI LILLY AND COMPANY, Indianapolis, Ind.
8	SWIFT & COMPANY, Chicago, Ill.
9	DAIRY COUNCILS OF INDIANA, Indianapolis, Ind.
10–11	PITMAN-MOORE COMPANY, Indianapolis, Ind.
12–13	PICKER X-RAY CORPORATION, New York, N. Y.
14–15	THE DICK X-RAY COMPANY, INC., Indianapolis, Ind.
16–17	THE KELLEY-KOETT MANUFACTURING CO., INC., Covington, Ky.
18	LAKESIDE LABORATORIES, INC., Milwaukee, Wis.
19	PET MILK COMPANY, St. Louis, Mo.
20	THE CENTRAL PHARMACAL COMPANY, Seymour, Ind.
21	BROOKS APPLIANCE COMPANY, Chicago, Ill.
22	AMERICAN HOSPITAL SUPPLY CORPORATION, Chicago, Ill.
23	A. S. ALOE COMPANY, St. Louis, Mo.
24	CAMERON SURGICAL SPECIALTY COMPANY, Chicago, Ill.
25	RADIUM AND RADON CORPORATION, Chicago, Ill.
26	C. B. FLEET CO., INC., Lynchburg, Va.
27	THE DOHO CHEMICAL CORPORATION, New York, N. Y.
28	REXAIR, INC., Detroit, Mich.
29	THE ARMOUR LABORATORIES, Chicago, Ill.
30	THE BAKER LABORATORIES, INC., Cleveland, O.
31	THE BORDEN COMPANY, New York, N. Y.
32	CAMEL CIGARETTES, New York, N. Y.
33	ABBOTT LABORATORIES, North Chicago, Ill.
34–35	THE MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
36	LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, New York, N.Y.
37	G. D. SEARLE & CO., Chicago, Ill.
38	LINCOLN LABORATORIES, INC., Decatur, Ill.
39	"JUNKET" BRAND FOODS, DIV. OF CHR. HANSEN'S LAB., INC., Little Falls, N. Y.
40	SPENCER, INCORPORATED, New Haven, Connecticut
41	MEAD JOHNSON & COMPANY, Evansville, Ind.
42	THE SMITH-DORSEY COMPANY, Lincoln, Nebraska
43	WHITE LABORATORIES, INC., Newark, N. J.
44	E. R. SQUIBB & SONS, New York, N. Y.
45	CUTTER LABORATORIES, Chicago, Ill.
46	VAN AUSDALL & FARRAR, Indianapolis, Ind.
47	HOLLAND - RANTOS COMPANY, INC., New York, N. Y.
48	BIOLOGICAL REFRIGERATION, INC., Indianapolis, Ind.
49	PHILIP MORRIS & COMPANY, LTD., INC., New York, N. Y.
50	W. B. SAUNDERS COMPANY, Philadelphia, Pa.

BOOTH 1
RICKRICH SURGICAL SUPPLY COMPANY
Evansville, Indiana

Rickrich Surgical Supply Company, Evansville, Indiana, deals in the nationally advertised lines of surgical supplies and equipment. Mr. I. J. Rickrich and Mr. George F. Carter, salesman, invite all visitors to inspect their exhibit at Booth No. 1.

BOOTH 2
H. J. HEINZ COMPANY
Pittsburgh, Pennsylvania

H. J. Heinz Company is displaying their Strained Foods for Infants and Junior Foods, especially designed for intermediate feeding. Their representatives would appreciate your recommendations regarding these foods.

They are presenting a new publication, *The Nutritive Value of Vegetables.* Examine, then register for it. A reminder—if desired, also register for the 12th edition *Nutritional Charts.* and *Nutritional Observatory.*

BOOTH 3
AMES COMPANY, INC.
Elkhart, Indiana

Ames Company representatives will demonstrate Clinitest, Albutest, and Hematest—simplified tests for the detection of urine-sugar, albumin, and occult blood.

They will be glad to discuss Decholin and Decholin Sodium.

Ames representatives who will be in attendance are Mr. B. E. Simmons, Mr. L. H. Reinheimer, and Mr. G. F. Norris, Sales Manager.

BOOTH 4
CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit, New Jersey

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, invite you to visit their exhibit for latest information on PYRIBENZAMINE, the new antihistaminic compound used for the relief of symptoms of allergy. Also featured will be PRIVINE Hydrochloride, the effective, long-lasting nasal vasoconstrictor; METANDREN Linguets, the most potent orally active androgenic hormone available in a suitable form for sublingual absorption; TRASENTINE, a synthetic antispasmodic capable of relieving spastic conditions of smooth muscle of the gastro-intestinal and urinary tracts; TRASENTINE PHENOBARBITAL, a synthetic spasmodic antispasmodic in combination with the well-known sedative PHENOBARBITAL.

Representatives in attendance will be glad to answer any questions concerning these and other Ciba Products.

BOOTH 5
PARKE, DAVIS & COMPANY
Detroit, Michigan

Members of PARKE, DAVIS & COMPANY'S MEDICAL SERVICE STAFF, fully informed regarding the progress in Pharmaceutical and Biological Research, and desirous of presenting various new advancements to you, will be on hand at our Technical Exhibit to discuss new and old products. Featured will be such outstanding specialties as—BENADRYL, VITAMINS, ADRENALIN, OXYCEL and THROMBIN, TOPICAL. Also, the most recent types of BIOLOGICALS, including other therapeutic agents of chemotherapeutic interest, will be displayed. We invite you to visit our Exhibit while attending this meeting.

BOOTH 6
CURTIS AND FRENCH
Indianapolis, Indiana

Curtis and French will feature all the very latest standard nationally advertised surgical equipment, with particular emphasis on pieces of equipment not generally shown by salesmen.

"Mac" McCain, Don Rowland, Bill Kroegher, and Jack Curtis will be in the booth to assist you.

BOOTH 7
ELI LILLY AND COMPANY
Indianapolis, Indiana

The Lilly exhibit this year features an interesting presentation on the heart and a discussion on cardiac drugs. Many Lilly products are to be on display; representative literature will be available. The attending Lilly medical service representatives will be pleased to assist visiting physicians whenever possible. Representative in charge, Mr. Edgar H. Schafer.

BOOTH 8
SWIFT & COMPANY
Chicago, Illinois

A new all-meat baby food, Swift's Meats for Babies (Strained) for very young babies, and Swift's Meats for Juniors (Diced) for older children, are being exhibited by Swift & Company. These high protein, body-building foods are available in six varieties—beef, lamb, veal, pork, heart, and liver. These products are also gaining rapid acceptance in special adult diet therapy. Representatives at the Swift & Company booth will be pleased to have you taste and examine these new products and to supply you with informative literature.

BOOTH 9
DAIRY COUNCILS OF INDIANA

The Dairy Councils of Indiana will feature an exhibit which shows how "Milk Completes Your Daily Meals." You are cordially invited to stop at the Dairy Council booth and examine our attractive health education materials.

The exhibit is sponsored by the Dairy Councils of Evansville, Fort Wayne, Indianapolis, Kokomo, Peru, and South Bend. These units are affiliated with the National Dairy Council of Chicago, Illinois, which is the health education organization of the dairy industry.

Dairy Council services and materials are free of charge in the localities which have affiliated units.

BOOTHS 10 and 11
PITMAN-MOORE COMPANY
Indianapolis, Indiana

The Pitman-Moore Company display, booths 10 and 11, will feature several new pharmaceutical research developments. One of these is Magmoid Sulf-Alka-Lac, a fluid combination of two sulfonamides and an alkali, designed to lessen the dangers ordinarily inherent in sulfonamide medication. Another is a combination of sulfathiazole and tyrothricin for topical application, known as Alginex Sulfathricin. A third, known as Alupec, and offered both in liquid and tablet form, offers a new approach to the oral administration of alkali for the treatment of conditions involving hyperacidity. In addition to the Company's Indiana representatives, W. A. Butler and J. R. Stewart, members of the Pitman-Moore Scientific staff will be on hand to answer questions concerning recent research and therapeutic advances.

BOOTHS 12 and 13
PICKER X-RAY CORPORATION
New York, N. Y.

The Picker X-Ray Corporation will exhibit a 100 M.A. Century unit for fluoroscopy and radiography in all positions from the Trendelenberg to the Vertical. This unit is self-contained and consists of transformer, control, tilting table, tube stand and tube, and vertical cassette holder for chest radiography.

There will also be on display a 60 M.A. "Comet" unit, a simplified radiographic and fluoroscopic apparatus which can be used with or without a horizontal bucky table.

BOOTHS 14 and 15
THE DICK X-RAY COMPANY
Indianapolis, St. Louis, Louisville, Memphis

The Dick X-Ray Company will have on display: Westinghouse X-Ray Equipment—Liebel-Flarsheim Short Wave Machines—Cambridge "Simpli-trol" Portable Electrocardiograph—Fluorescent Viewers—Physiotherapy Equipment.

BOOTHS 16 and 17
THE KELLEY-KOETT MANUFACTURING CO.
Covington, Kentucky

On display in booths 16 and 17 are the new American Electric Diagnostic Unit, Mobile Unit, and Non-Tilt X-ray Table, offering a complete range of service in fluoroscopy and radiography for the office, clinic, or hospital. The Diagnostic Unit and Mobile Unit each incorporate the unique Powerhead with its replaceable cartridge eliminating the need for a serviceman. This self-contained Powerhead provides simplicity, efficiency, and dependability to a greater degree than other units of comparable rating. These features make possible a guarantee and service policy never before offered in the x-ray field.

BOOTH 18
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin

The Lakeside exhibit will feature Mercuhydrin, well tolerated mercurial diuretic; Estrogens, Lakeside; and Emulgen, emulsifying vehicle for penicillin. Representatives will be on hand to describe the applications of these medications.

BOOTH 19
PET MILK SALES CORPORATION
St. Louis, Missouri

A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

BOOTH 20
THE CENTRAL PHARMACAL COMPANY
Seymour, Indiana

Our display will feature a new treatment for rheumatic fever and the new triple-sulfa therapy for use in treating adults and children. In addition, we shall show a limited number of specially developed tablets for use in treating various conditions in children. This line of tablets is known as Palatabs.

BOOTH 21
BROOKS APPLIANCE COMPANY
Chicago, Illinois

The Brooks Appliance Company of Chicago will display a line of bandages, proctological instruments, needles, and syringes.

Mr. W. C. Ayer will have charge of the booth and will feature the Combination Pressure Bandages, Contura plus Pressoplast, which is used in treating leg ulcers and phlebitis.

BOOTH 22
AMERICAN HOSPITAL SUPPLY CORPORATION
Evanston, Illinois

The American Hospital Supply Corporation will present in its Exhibit Baxter Parenteral Products—Solutions and Equipment, Tomac Selected Products, and a wide array of equipment and supplies for the hospital. In this year's exhibit recent important

hospital products will be stressed as significant contributions to economy, convenience, and service in the hospital. This will include Baxter's Protein Hydrolysate and Disposable Tube and Needle Sets, Tomac Spongettes, the Vasocillator and Rh serum.

Mr. Howard Henderson and Mr. Russell Price will be in charge of the exhibit. They cordially invite all visitors to stop by the American Exhibit, not once, but as many times as possible. They will welcome questions and inquiries from Convention guests.

BOOTH 23

A. S. ALOE COMPANY

St. Louis, Missouri

The Indiana representatives of the A. S. Aloe Company, Mr. E. Rattner and Mr. B. W. Weisiger, will welcome their friends at booth No. 23 where they will have on display a representative cross section of our complete line of Surgical, Hospital, and Laboratory equipment and supplies. Featured will be a complete line of government surplus instruments available at the present time—especially selected, fully certified instruments at approximately one half the regular cost.

BOOTH 24

CAMERON SURGICAL SPECIALTY COMPANY

Chicago, Illinois

See the new Cameron Cauterodynes and Cauteradios for Electro-coagulation, Electro-cauterization and Electro-surgery; Coagulair-Sigmoidoscope; Electro-Diagnostosets; Flexible Gastroscopes; Bronchoscopes-Esophagoscopes-Laryngoscopes; Mirrolite; Binocular Spectacle Loupe; Magniscope and other Specialties.

BOOTH 25

RADIUM AND RADON CORPORATION

Chicago, Illinois

The Radium and Radon Corporation will exhibit radium tubes, needles, and accessories. Radon implants and accessories will also be shown.

Complete information will be available on the sales and leasing plans of Radium and Radon.

Representative in attendance will be Mr. Charles F. Bergesch.

BOOTH 26

C. B. FLEET CO., INC.

Lynchburg, Virginia

C. B. Fleet Co., Inc., welcomes you to the Technical Exhibits, and cordially invites you to Booth No. 26 where it is proud to exhibit Phospho-Soda (Fleet), the one product of its manufacture. Phospho-Soda (Fleet) has come to occupy a significant position wherever sodium phosphates or other salines are indicated. It is a pure, stable, aqueous concentrate of the two U.S.P. Sodium Phosphates with a history of more than fifty years of manufacture and ethical distribution. Should you not be thoroughly acquainted with Phospho-Soda (Fleet), the representative at the booth will discuss with you the chemistry, advantages, and possible application of Phospho-Soda (Fleet) in your practice. Our representative, Mr. A. M. Kirkpatrick, will be in full charge of our convention activities.

BOOTH 27

THE DOHO CHEMICAL CORPORATION

New York, N. Y.

The Makers of AURALGAN are introducing at this Meeting their new sulfa drug preparation O-TOS-MO-SAN, indicated in the treatment and control of chronic suppurative ears. Our Representatives will be happy to explain, in detail, the workings of these medications, also to distribute our latest series of three (3) Anatomico-Pathologic Charts of the Ear, in color, suitable for framing.

Mr. Herbert H. Bacon of Indianapolis will be in charge of our exhibit.

BOOTH 28

REXAIR, INC.

Detroit, Michigan

Rexair is a portable air cleaner that performs many household and hospital jobs. It purifies, deodorizes, and humidifies the air; cleans floors, walls, and furniture; scrubs floors; draws in dust-laden air and sends out clean, moist air. Dirt is trapped in water, poured down the drain. There is no bag to empty.

BOOTH 29

THE ARMOUR LABORATORIES

Chicago, Illinois

The Armour Laboratories, a pioneer in the field of Endocrinology, will welcome members of the Indiana State Medical Association to visit the Armour exhibit in booth No. 29.

If you have not received your copies of books on "The Thyroid Gland and Clinical Application of Medicinal Thyroid," "Function and Malfunction of the Biliary System," and the "Armour ATLAS of Hematology," you may secure them at the Armour booth.

BOOTH 30

THE BAKER LABORATORIES, INC.

Cleveland, Ohio

The Baker display is built around the six-step approach to optimum infant nutrition which leads to the picture of the happy mother and the healthy child. An adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron, coupled with simplicity of preparation and low cost, provide for complete nutrition and insure co-operation in the home. Baker's Modified Milk, liquid or powder, may be used interchangeably from birth to the end of the bottle-feeding period. May we discuss your infant feeding problem with you?

BOOTH 31

THE BORDEN COMPANY

New York, New York

Spend a few pleasant minutes with Borden at Booth No. 31 and refresh your memory on our Prescription Products. Meet BIOLAC, a liquid modified milk for infant feeding; DRYCO with its high-protein, low-fat content for formula flexibility; MULL-SOY, a liquid hypoallergenic soy food for your milk allergic patients; powdered whole milk KLIM, a dependable source of whole milk; the improved milk sugar, BETA LACTOSE, for carbohydrate supplementation; and the powdered MERRELL-SOULE PROTEIN and LACTIC ACID MILKS for special infant feeding cases.

We invite your attention to PROTOLAC, a new, especially-formulated blend of intact proteins and high protein products derived from animal and vegetable sources. PROTOLAC is supplemented with choline and the amino acid cystine. PROTOLAC is indicated in high protein therapy in conditions requiring increased dietary protein of optimum nutritional value.

BOOTH 32

CAMEL CIGARETTES

New York, N. Y.

CAMEL Cigarettes will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nation-wide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

BOOTH 33

ABBOTT LABORATORIES

North Chicago, Illinois

You are cordially invited to visit our exhibit, where Abbott-trained Professional Service Representatives in attendance will be happy to discuss with you the newer developments in the antibiotic, anticonvulsant, anesthetic, allergenic, sulfonamide, hematinic, hormone, vitamin, and other fields.

Representatives in attendance will be: Harold Clauson, Duane W. Witt, E. G. Moss.

So, be sure to visit Booth No. 33.

BOOTHS 34 and 35

MEDICAL PROTECTIVE COMPANY

Fort Wayne, Indiana

The Medical Protective Company's representatives, Kenneth W. Moeller and Robert F. Reiman, thoroughly trained in Professional Liability underwriting, invite you to visit exhibit booths No. 34 and No. 35. They are entirely familiar with the principles of the reciprocal rights and duties of a doctor and patient and with the circumstances peculiar to that relationship. They will be glad to explain how the Company meets the exacting requirements of adequate liability protection, which are peculiar to the Professional Liability field.

BOOTH 36

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY

New York, N. Y.

Lederle Laboratories will provide an up-to-date display covering several of the recent advances in medicine contributed by this company.

Folvite folic acid will be shown in its original tablet form as well as in an elixir suitable for dosage in children. Folvron, containing both folic acid and ferrous sulfate, will likewise be shown.

Alcohol refinement will be shown in its application to the preparation of diphtheria and tetanus toxoids. The highly accurate new syphilis diagnostic, involving the Cardiolipin Lecithin Cholesterol mechanism, will be displayed. In addition, protein nutrition and its relation to Ledinac, a protein hydrolysate, will be discussed.

BOOTH 37

G. D. SEARLE & CO.

Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Hydryllin, the new antihistaminic, as well as such time-proven products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraqnin, Kiophyllin, Diodoquin, Pavatrine and Pavatrine with Phenobarbital.

BOOTH 38

LINCOLN LABORATORIES, INC.

Decatur, Illinois

Lincoln Laboratories, Inc., of Decatur, Illinois, will show Aqueous Suspension of Estrogenic Substances, 10,000, 20,000, and 50,000 International Units per cc., which offers, in a Council Accepted medication, a wider range of Aqueous Estrogens than are available anywhere. Also to be shown are such products as Liverplexir, a combination of Liver Extract, Iron, and all of the known B-Complex factors—a fine, heavily concentrated medication for the treatment of pernicious, hypochromic, and secondary anemia. Also to be shown will be various of our hormone products, including Aqueous Suspension of Androlin (testosterone), Aqueous Suspension of Progesterone, Aqueous Estroluteum, which includes Estrogenic hormone 20,000 I.U., plus Progesterone 10 mg. All three of these aqueous suspensions are original and exclusive with Lincoln Laboratories—the Pioneer in the development of Hormone Aqueous Suspensions. Advance information regarding the new heart drug, Digophyllin, will also be available. This cardiac glycoside offers all the advantages of digitoxin, besides not causing the vaso-constriction common to the digitalis drug.

BOOTH 39

"JUNKET" BRAND FOODS

Division of Chr. Hansen's Laboratory, Inc.

Little Falls, New York

Enlarged photos illustrate the action of the rennet enzyme in forming softer, finer milk curds. Free literature describes dietary uses of rennet desserts in infant, child, convalescent, or postoperative feeding. Attendants on duty. Complimentary package of "Junket" Rennet Powder and "Junket" Rennet Tablets presented to physicians who register.

BOOTH 40

SPENCER, INCORPORATED

New Haven, Connecticut

You are cordially invited to visit our exhibit, featuring Spencer Individually Designed Supports for abdomen, back, and breasts.

Each Spencer Support is individually designed, cut, and made to meet the specific posture and health needs of the one patient who is to wear it. This assures you that the support will be correct, from the standpoint of body mechanics, that it will fit exactly, and be completely comfortable.

On display are supports for patients following mastectomy and other postoperative conditions, hernia, obesity, back derangements, visceroptosis and nephroptosis with symptoms, antepartum and postpartum needs.

BOOTH 41

MEAD JOHNSON & COMPANY

Evansville, Indiana

Amigen and Protolysate will be on display at the Mead Johnson Exhibit at your Indiana State Medical Association Meeting. Mead Johnson has pioneered the amino acid field, commercially; the products have been described in more than one hundred and forty articles in the medical literature; this year they are available. Trained representatives will be at the Mead Exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum, and the other Mead Products used in Infant Nutrition. Protenum, a new high-protein product will be displayed. Also Lonalac for low-sodium diets.

BOOTH 42

THE SMITH-DORSEY COMPANY

Lincoln, Nebraska

Estrogenic Hormone, Liver, and other parenteral products will be featured in the Dorsey exhibit. Dorsey representatives welcome you to the exhibit every day.

BOOTH 43
WHITE LABORATORIES, INC.
Newark, N. J.

White's Dienestrol Tablets—a new orally effective synthetic estrogen—is featured. Complete information and literature are available regarding the advantages of Dienestrol's high biologic activity, excellent patient-tolerance, and economy.

Other products of White Laboratories are on display, and White's Medical Service Representatives in attendance will be pleased to supply any further information requested.

BOOTH 44
E. R. SQUIBB & SONS
New York, N. Y.

Presenting a wide variety of newly released Squibb preparations for prescription use.

Representatives in attendance will be: Mr. P. S. MacDougal, in charge; Mr. H. J. Fry, Mr. J. H. Kennington, Mr. H. C. Foster, Mr. E. R. Harris, Mr. L. C. Strandberg.

BOOTH 45
CUTTER LABORATORIES
Chicago, Illinois

CUTTER LABORATORIES will display biologicals, a complete line of human blood fractions, penicillin, intravenous solutions, blood transfusion and plasma preparation equipment.

BOOTH 46
VAN AUSDALL & FARRAR
Indianapolis, Indiana

Ediphone Voicewriting instruments, manufactured by Thomas A. Edison, Incorporated, will be presented by Van Ausdall & Farrar, Indiana Distributors, with offices at Indianapolis, Evansville, and Fort Wayne. This exhibit will be featured by Edison's new postwar Electronic instruments, the Mercury and the Director, True fidelity voice recording, so important for the use of medical terms, now becomes available to the physician and surgeon. Mr. L. E. Grisso and Mr. J. E. Shields will be on hand in Exhibit 46 to demonstrate these instruments to you.

BOOTH 47
HOLLAND-RANTOS COMPANY, INC.
New York, Los Angeles, Chicago

You are cordially invited to visit the Holland-Rantos booth, where on display will be the nationally known and universally used Koromex contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, there will be the new Nylmerate Jelly, introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin.

Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koromex Jelly will be available, as will be copies of the new physician's patient instruction chart.

BOOTH 49
PHILIP MORRIS & COMPANY, LTD., INC.
New York, N. Y.

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject and problems on the physiological effects of smoking.

BOOTH 50
W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

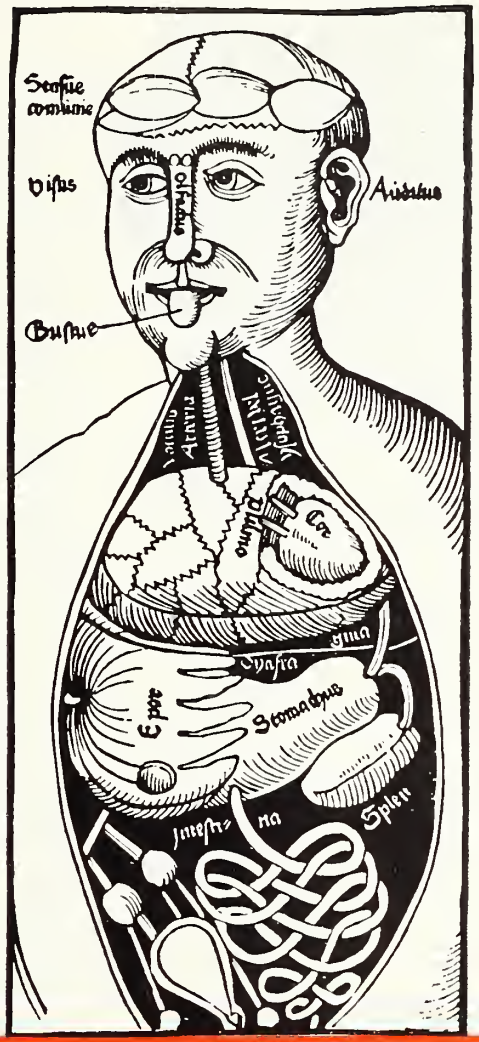
This Company will exhibit the complete line of their books, including Hyman's "Integrated Practice of Medicine," Bockus' "Gastro-enterology," Rubin's "Diseases of the Chest," Cooke's "Allergy," the 1947 Mayo Clinic Volume, new editions of Wechsler's "Clinical Neurology," Ranson & Clark's "Anatomy of the Nervous System," Novak's "Gynecological and Obstetrical Pathology," Cecil's "Medicine," DeLee & Greenhill's "Obstetrics," Wharton's "Gynecology and Female Urology," Boyd's "Surgical Pathology," Duncan's "Diseases of Metabolism," McCombs'. "Internal Medicine," the American Illustrated Medical Dictionary, Bastedo's "Materia Medica and Pharmacology," and many others. Representatives in charge: J. A. Lutz, Sales Manager, and Brooks J. Hibbitt, Indiana representative.

STAY AWAY FROM FRENCH LICK and you will miss the greatest scientific program in the ninety-eight years' history of the Indiana State Medical Association.

TOM COLLINS WILL BE SERVED at the annual banquet. He is not a drink, but a humorist, philosopher, editor, banker, entertainer, and after-dinner speaker. He is better known and more in demand than the famous gin drink of similar name. He is another big reason why everybody is planning to attend the banquet.

AS USUAL, the unusual in entertainment is being planned by the Southern Indiana boys for the French Lick Session.

YOU NEED NOT BE an expert bowler to enter the bowling tournament in the new Casino at French Lick on Wednesday night. There will be prizes for both low and high scores and special events for beginners.



Anatomic woodcut: Title poge from Pyligk Compendium; 1516—Courtesy, The Bettmonn Archive

IN 1516:

Anatomic illustrations were crude; knowledge of the anatomy and the treatment of diseases of the heart and thoracic organs were extremely limited.

today: SEARLE **AMINOPHYLLIN***

is widely employed in selected cardiac cases, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

G. D. Searle & Co., Chicago 80, Illinois

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Seorle Aminophyllin contains ot least 80% of onhydrous theophylline

SEARLE RESEARCH IN THE SERVICE OF MEDICINE



AMES

DIAGNOSTIC AGENTS

Simple, Reliable, TABLET Methods for Quick Detection of

OCCULT BLOOD • ALBUMIN • URINE-SUGAR

HEMATEST

Tablet method for rapid detection of occult blood in feces, urine and other body fluids. Bottles of 60 tablets.

ALBUTEST

Tablet, *no heating* method for quick detection of albumin. Bottles of 36 and 100 tablets.

CLINITEST

Tablet, *no heating* method for detection of urine-sugar.

Laboratory Outfit.

Plastic Pocket-size Set.

Clinitest Reagent Tablets 12x100's and 12x250's for laboratory and hospital use.

AMES COMPANY, Inc.

ELKHART, INDIANA

News Notes

Obstetrical and Gynecological Society Meeting

The Indianapolis Obstetrical and Gynecological Society will hold its first scientific meeting at 6:30 p.m. on October 22, 1947, at the Athenaeum, Indianapolis. This will be a dinner meeting and tickets will be $5.00 each. Members are requested to make reservations not later than October 20 through the office of Dr. Lawson J. Clark, Secretary, 420 Hume Mansur Building, Indianapolis.

Dr. Paul M. Berger is now associated with Dr. John A. Mirro for the practice of medicine in Lowell.

Elkhart county commissioners have named Dr. W. R. Kelley, of Goshen, to succeed Dr. C. K. Bender, also of Goshen, as Elkhart County health officer. For the past four years Dr. Kelley has been city health officer.

Dr. Leon Kresler, of Rensselaer, has been appointed Jasper County coroner.

Dr. A. W. Lloyd has announced the opening of an office at 8237 Forest, Munster, for the treatment of conditions of the eye.

Announcement has been made of the resignation of Dr. O. R. Lynch as superintendent of the Richmond State Hospital.

Dr. Harry N. McClelland, formerly of Indianapolis, has joined the New Castle Clinic where he will specialize in internal medicine. Dr. McClelland is a veteran of World War II, having served for four years in the army medical service.

Dr. Orville H. Richer, of Warsaw, has been named Kosciusko County coroner, to fill the unexpired term of Dr. Leslie Laird, who recently resigned to become resident physician at the East Haven State Mental Hospital, in Richmond.

Colonel Edwin M. Goyette, United States Army Medical Corps, has been appointed Assistant Professor of Military Science and Tactics on the faculty of the Indiana University Medical School. Colonel Goyette will also serve on the University's hospital staff as a resident in cardiology. A native of Vermont, Colonel Goyette received his B.S. degree from the University of Vermont, in 1929, and his M.D. degree from the same institution, in 1932. He served as intern in the Fanny Allen hospital at Winooski, Vermont, and the Vassar Brothers hospital at Poughkeepsie, N.Y., prior to entering the Medical Corps in 1925. During the past year he served as resident on the staff of the Fitzsimmons General Hospital at Denver.

Dr. William G. Clevinger, of Indianapolis, was separated from the service October fifth, with the rank of captain. He entered the service October 12, 1945, at Camp Carlysle, Pennsylvania, then went to Brook General Hospital, at Fort Sam Houston, Texas. From there he went overseas, and spent approximately a year in Japan and Korea. Doctor Clevinger's future plans are indefinite.

Dr. Charles J. Aucreman, formerly of Montpelier, has announced the opening of an office for the practice of ophthalmology at 401 Wysor Building. in Muncie. Doctor Aucreman was released from the service in September, 1945, after serving with the Army Air Corps for fifty-eight months. Since his release from the service he has taken a postgraduate course in ophthalmology at Washington University, in St. Louis, and served for one year as resident in ophthalmology at Cleveland City Hospital.

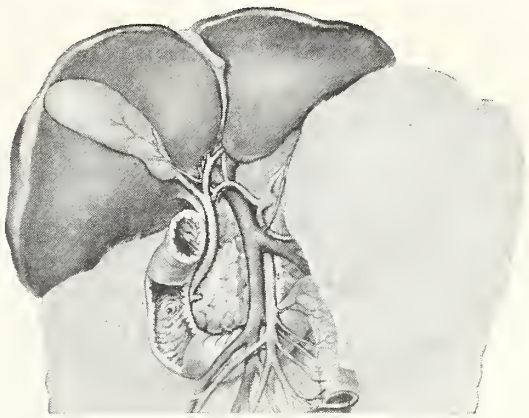
A comprehensive exhibit on the Congenital Abnormalities of the Head was presented during the annual convention of the American Roentgen Ray Society, Sept. 16-19, at Atlantic City by Dr. John A. Campbell, Associate Professor of Radiology, at the School of Medicine, and Dr. Willard C. Smullen, Instructor in Radiology at the Medical Center.

Two Indiana men will participate in the fall graduate instructional course of the American College of Allergists, which will be held November 3-8, 1947, in Cincinnati. They are Dr. Paul Moore, of Muncie, and Dr. Hugh A. Kuhn, of Hammond.

Drs. Carl P. Huber, Sprague H. Gardiner, and Charles O. McCormick, Sr., of Indianapolis, and Dr. Frank W. Peyton, of Lafayette, participated in the program of the Third American Congress on Obstetrics and Gynecology held last month in St. Louis.

Dr. Thomas A. Brady has announced his association in the practice of Orthopedic surgery with Dr. Charles F. Thompson, at 320 Hume Mansur Building, Indianapolis. Doctor Brady is a graduate of the Indiana University School of Medicine, and had three years of training at Indianapolis City Hospital prior to serving for four years in Army Air Force stations and regional hospitals.

Dr. Carl H. McCaskey, of Indianapolis, recently was elected second vice-president of the American College of Surgeons at its annual meeting in New York.



In Cholangitis . .

Decholin produces hydrocholeresis, flushing the bile ducts, removing accumulated mucus and inspissated bile.

In Cholecystitis . .

Decholin relieves stasis, discourages ascending infection, promotes drainage.

In Biliary Surgery . .

Decholin fits well into the postoperative routine by materially helping to keep the bile passages free from offending debris.

HOW SUPPLIED: *Decholin* in 3¾ gr. tablets. Boxes of 25, 100, 500 and 1000.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Decholin

Reg. U. S. Pat. Off.

(dehydrocholic acid)

AMES COMPANY, Inc.

Successors to Riedel-de Haen, Inc.

ELKHART, INDIANA

Dr. John Beardsley has become associated with his father, Dr. Frank Beardsley, in the practice of medicine at 51 South Jackson Street, Frankfort.

Dr. Phyllis Catt, who is affiliated with the Indiana University Medical Center, at Indianapolis, and Dr. Charles P. A. Zerfas, who is a member of the staff of the Indianapolis City Hospital, were united in marriage on June thirtieth.

Dr. Paul R. Hawley, chief medical director of Veterans Administration, who was officer-in-charge of all medical care in the European Theater of Operations during World War II, has been awarded the Gorgas Award for 1947. The award is given annually by the executive council of the Association of Military Surgeons to some person who has made a notable contribution in the field of military medicine. It is sponsored by Wyeth, Incorporated, of Philadelphia. The presentation will be made at the association's annual meeting in Boston, November 13-15. Dr. Hawley, who retired from active duty with the Army on June 30, 1946, with the rank of major general, is a native of Indiana. He had a long and distinguished career in the Army and has an impressive medical background.

Grants for Scientific Research

The American Allergy Fund announces the availability of grants in aid for research. Grants will be made to investigators in the biological sciences, both medical and non-medical, whose problems meet the requirements of the Scientific Advisory Council. Preference will be given problems with immediate relationship to allergy, although investigations in physiology, biochemistry, pharmacology, immunology, genetics and other basic sciences are solicited. Applications should contain the following information:

1. Statement of specific research problems and an outline of the method or methods of procedure to be followed.
2. Description of research facilities in the institution where investigator will employ the grant.
3. A tentative budget.
4. Statement of the applicant's research record, accompanied, if possible, by publications or reprints.

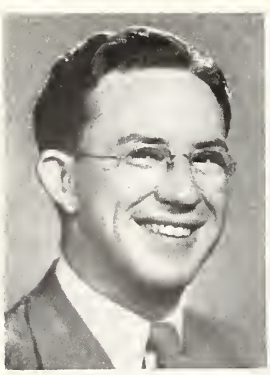
Grants will be made for one year in amounts not to exceed $3,500, and may be renewed from year to year if the progress report warrants continuation. Applications (seven copies) should be addressed to the American Allergy Fund, 525 Erie Building, Cleveland 15, Ohio, attention: Scientific Council.

Four Medical Students Receive Scholarships

Scholarships worth $500 a year recently were awarded to four students of the Indiana University School of Medicine by the Indiana State Medical Association. They are: Carl H. Ault, Indianapolis; Fred W. Dierdorf, Jr., Terre Haute; Earl R. Leinbach, Goshen; Herbert C. Ashmore, Lafayette. Mr. Ashmore and Mr. Leinbach are beginning students, while Mr. Ault and Mr. Dierdorf are sophomores. Mr. Ault and Mr. Ashmore are veterans.

In making the announcement, Dr. Cyrus J. Clark, chairman of the association's Committee on Medical and Nursing School Scholarships, said:

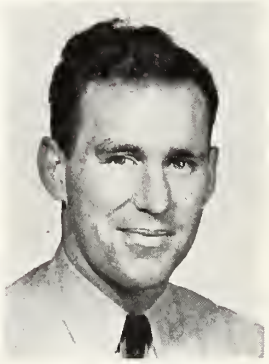
"Upon completion of their internships, the boys have agreed to practice medicine for at least five years in some Indiana community which does not have adequate medical services. Through the scholarships the medical association hopes to encourage more young men to study for general practice and to open offices in areas short of doctors. If this can be accomplished, our association will make a definite contribution toward solution of the problem of better medical care in smaller communities of the state."



FRED DIERDORF



CARL AULT



H. C. ASHMORE



EARL LEINBACH

Mothers

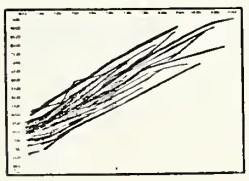
APPRECIATE THE SIMPLICITY OF PREPARING FEEDINGS



The preparation of Similac feedings requires only the addition of Similac powder to previously boiled, tepid water—in the proportions you prescribe. Mixing requires only 20 to 30 seconds. The simpler your directions to the mother, the less chance of error on her part. And simpler procedure in preparing feedings makes sanitation easier.

Physicians

LIKE THE UNIFORM RESULTS



Similac is simple to prepare . . . Modern . . . Ethical. It gives uniformly good results.



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A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

SIMILAC *Similar to breast milk*

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Medical Panorama by the Associate Editor

ROCKY MOUNTAIN Medical Journal announces that the Montana State Medical Association will join in sponsorship of the Journal in January, 1948. Formerly allied with Journal-Lancet, Montana becomes the fifth state to share sponsorship with Colorado, Wyoming, Utah, and New Mexico.

———SIMA———

PHILADELPHIA MEDICINE warns against the increase in fake medical cures and appliances sweeping the country. Vapor bath systems for diabetics at $2,200; electric shock apparatus for liver abscess, heart disease, and cancer at $1,200; a device for administering an enema for arthritis, rheumatism, stomach ulcers, and other ailments at $1,900. They particularly warn physicians to exercise great care in purchasing diathermy equipment and other appliances, and to be certain that they conform to the regulations set forth by the Federal Communications Commission.

———SIMA———

PITTSBURGH reports "the official tabulation of the statistics coming from the Surgeon General's office on the 5,000,000 men between the ages of 18 and 37 whom the draft boards during World War II classified as 4F's":

500,000	never examined because of evident mental or physical defects.
676,000	rejected because of deficient intelligence.
10,000	rejected because they were morons or idiots.
856,000	rejected because of neuropsychiatric shortcomings.
376,000	disqualified with physical defects such as hunchbacks, amputations, etc.
65,700	rejected for flat and club feet.
317,500	rejected because of heart trouble.
260,200	disqualified because of hernia.
245,400	rejected because of nerve injuries resulting from infantile paralysis, etc.
234,300	rejected for bad eyesight.
189,700	rejected for defective hearing.
129,900	rejected because of tuberculosis.
64,700	rejected for kidney weakness, enuresis, etc.
65,700	rejected for gastro-intestinal illness.
48,200	rejected for varicose veins.
45,300	rejected for gland defects.
19,300	rejected for hemorrhoids.
254,000	rejected for syphilis.
18,400	rejected for venereal disease other than syphilis.
15,000	seriously underweight.
10,000	greatly overweight.

DETROIT turns over the publication of its *Medical News* once each year to the Woman's Auxiliary.

———SIMA———

NORTHWEST MEDICINE is not too sanguine about the future of prepaid medical care plans. The increasing demand for service, under these programs, as evidenced in statistical reports from numerous sources, raises the question as to whether many will be able to adjust themselves to rising costs, and also if they will really serve "the best interests of the country and its economy." The fear is expressed that the demand for service will exceed the ability to supply it and the attempt to do so may prove economically unsound because of the increased cost entailed. The conclusion is suggested "that the system of direct exchange of money for service is the best one after all."

———SIMA———

JACKSON COUNTY (Missouri), through the Editor of their Bulletin, has this to say about federalized "Health Insurance."

"After reading through a very considerable amount of material both for and against federalized medicine there are certain conclusions which are obvious: (1) proof is wanting that any nation has been made healthier because of these insurance schemes, (2) the rejection rate of draft-age men in countries having compulsory medical care was higher than in our country, (3) preventive medicine in countries covered by state medicine is less in evidence than in our country, (4) political medicine (by whatever name) invariably builds up an army of office-holders wherein the expense and the proportion of lay administrators to the number of doctors and the services rendered is inordinately high, (5) absenteeism from work and the time lost because of illness (actual or that illness only existent as certified to by a physician) has always increased whenever any country introduced 'health insurance,' (6) the type of practice and the quality of service rendered to people has fallen inexorably with this type of blanket coverage, (7) proposed services have always resulted in either, (a) exhausting the funds available (as in New Zealand), resulting in bankruptcy of such schemes, or (b) in depleting the allocated amount of funds to such a degree that the services actually rendered become inferior.

"No matter what exalted position is occupied by those who mouth these platitudinous phrases such as 'health insurance,' it is a challenge, it is our right and our duty to inquire: what do they mean by 'health insurance?'"



Replacing Turmoil with Serenity

Replacing turmoil with serenity for women undergoing menopausal disturbances has become a matter of comparatively specific therapy.

Choice of an estrogenic product in this condition is likewise well charted. For optimum relief of symptoms, the competent physician selects a product whose manufacturing history he need never question.

This, perhaps, may account for the wide use of Solution of Estrogenic Substances, Dorsey. Made by Smith-Dorsey Company, whose plant facilities, personnel and procedure are above reproach, these products merit the continuing confidence of careful doctors.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Dorsey

Solution of Estrogenic Substances

THE SMITH-DORSEY COMPANY, Lincoln, Nebraska

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Patronize Your Advertisers

KENTUCKY has had phenomenal success in raising over $150,000 in voluntary contributions toward their scholarship fund. This fund will be used to pay tuition for those students agreeing to practice in rural areas.

———— S I M A ————

OKLAHOMA editorializes the "specialty problem" and concludes: "It appears high time that we abandon the 'brain trusters' in medicine as a guide to policy. We are indebted to them for scientific and technical knowledge, but we must resist any effort to deprive the public of the general practitioner. Nor can we deprive him of adequate hospital facilities. It is sincerely hoped that no Oklahoma hospital, not even excepting the University Hospital, will go off the deep end and exclude men who have served them and the people faithfully in the past but who have not become specialists on paper."

———— S I M A ————

NEW YORK MEDICINE quotes the recent message of President Truman, again urging national health insurance, which concludes to the effect that unless adopted we "shall be perpetuating unnecessary misery and human suffering." In contrast they call attention to the coincidental Statistical Bulletin of the Metropolitan Life Insurance Company which indicated that "fewer Americans are dying and more are living longer than ever before." The Bulletin shows a new high of life expectancy, 66 years for 1945, an increase of two years and three months. They conclude: "It seems pertinent to ask our fellow citizens, including President Truman, whether, in view of this impressive and uninterrupted record of gains in the unending war against disease and death, the time is really propitious for a radical alteration of the American program of health and medical care?"

———— S I M A ————

NEW YORK, through Louis H. Bauer, president-elect of the State Society:

"There are now about 130,000 members of the American Medical Association, and if I say that 2,500 of them are active in protecting the interests of the public and medicine, I would probably exaggerate. These men are devoting a tremendous amount of time and thereby cutting their own incomes to protect the profession and the public. It is somewhat discouraging to them sneeringly to be referred to by their associates in medicine as 'medical politicians.' Were it not for the efforts of this group, all of us would now be practicing under a plan of bureaucratic regimentation. If the members of a county society do not like the way their affairs are handled, then they should attend meetings and change the methods and their officers. If they do like them, then they should attend and give their officers support."

PHILADELPHIA MEDICINE calls attention to the "tragedy of old age," and indicates that in 25 years those 65 or over will be more than double the present number, while the number between 20 and 65 will remain stationary. The strain on municipal and state hospital facilities is already great and the ability of relatives to care for the aged appears overtaxed. The "virgin territory" of gerontology and geriatrics is indicated, and the necessity for a wider vision on the part of the profession, in anticipating and preparing for the care of the aged, should provide an opportunity and worth-while endeavor in this special field.

———— S I M A ————

OHIO, through their House of Delegates, agrees that "Specialty Board membership is not necessary as a prerequisite for hospital staff appointment." The House also adopted a resolution, a pertinent part of which was to the effect that: "The staff of each Ohio hospital should revise its rules, constitution and by-laws governing staff privileges, if necessary, to provide that staff membership shall be dependent on the merits, training, and experience of the physician, not on certification by a specialty board or membership in a special society, and to provide that all members of the staff shall be accorded the right to vote, hold office, and serve on committees."

———— S I M A ————

CLEVELAND has an excellent method of maintaining good public relations in keeping the newspapers "promptly and accurately informed." Through the Health Education Committee of their Academy of Medicine weekly press conferences are arranged with representatives of the Cleveland papers. Quoting from a report in the Ohio State Medical Journal:

"The Committee secures qualified speakers who talk informally with the representatives of the newspapers, outlining recent advances in particular fields of medicine. These informal discussions enable the science writers to interpret and evaluate medical articles better, thus making far more accurate reporting.

"Whenever possible, the newspapers are furnished digests of papers presented before the local and national medical organizations. Also, as in the past, the Chairman of the Health Education Committee of the Academy will continue to secure at any time a member of the Academy to speak for quotation in the newspapers in connection with legitimate medical news items.

"There is no reason why most of the county medical societies could not arrange similar conferences, on a smaller scale if necessary.

"Also, it is suggested that consideration be given to inviting news commentators of local radio stations to sit in. They, too, should be considered a member of the Fourth Estate."



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What's Going On In Indiana by the Executive Secretary

Don't Miss The Exhibits. While you are attending the annual session at French Lick this month —about which you have heard so much from the prolific pens of Drs. A. P. Hauss and Clarence E. Boyd, co-chairmen of the Committee on Convention Arrangements—don't neglect the scientific and technical exhibits. You will find them all very much worth your while. The scientific display will be just outside and immediately inside the entrance to the convention hall. Take time before and after meetings to study them. The entire mezzanine floor will be given over to the technical exhibits. This is your opportunity to learn more about the pharmaceuticals, surgical supplies, x-ray equipment, and other wares of reputable concerns. The exhibitors attend the annual meeting at great expense, and they are entitled to consideration. We urge you to visit each booth.

——ISMA——

Public Relations. The medical profession was never as public relations conscious as it is today. The American Medical Association has debated the issue for two years, but has not as yet decided upon a definite program. Most state medical associations recognize the problem. Some, notably Michigan, Ohio, Florida, Oklahoma, and Colorado, have inaugurated public relations programs, and at great expense. In most cases the money has been raised by a special assessment of $25 a year upon each member. With some exceptions, the programs follow the accepted public relations methods which are advertising and news articles, radio talks and playlets, public speaking, printed literature, et cetera. The profession needs more good will, no question about that, but will these types of activities produce it? Are the doctors' dollars being wasted? Officers of the Indiana State Medical Association have decided—and we think wisely—upon a policy of watchful waiting. Meantime, Indiana medicine is doing a pretty good job. Our doctors, with maybe a few exceptions, are giving the people good medical care at reasonable charges. That is, undeniably, the best public relations for medicine.

——ISMA——

Telephone Calls. It was the Saturday morning before Labor Day and the executive secretary was manning the state headquarters office. That meant he had to answer the telephone, and in so doing, had an opportunity to learn about the kind of calls that come to the girls in the outer office each day. It was interesting to him, and maybe it will be of interest to you. The first call was to inquire about the name of a doctor at Muncie, his initials and office address. That was easy. Then a woman living on West Tenth street who had a "lovely room for a doctor's office" to rent wanted to know the names of doctors looking for office space. She was referred to the Indianapolis Medical Society. We just returned to our work when the phone rang again. A woman's voice said her father was going to a Doctor ———— for an operation at his private hospital, and wanted to know if he was a reputable physician. The answer: "He is not a member of the county or state medical association, so you can draw your own conclusion." Came a call from another woman for names of "rectal specialists." Names are not given over the phone, but the list, taken from the A.M.A. directory, would be mailed to her, if she desired. "If you will, please," she said. A long distance call arrived from a southern Indiana doctor asking the e.s. to get him a hotel reservation for the next Wednesday night. The phone rang again. The voice asked for Harry. "No Harry here." And as the morning drew toward an end, we were asked about the reputation of Doctor ———— who operates a cancer hospital in a Tennessee city. Not finding his name or the hospital in the A.M.A. directory, the party was advised to write to the office of the Tennessee State Medical Association for the information. And such are the telephone calls that come to the association's office!

——ISMA——

This and That. Dr. John Van Nuys, dean of the Indiana University School of Medicine, will address the House of Delegates Tuesday afternoon, October 28, on invitation of the Council . . . With seven county societies still to be heard from, names of 202 doctors in practice for fifty years or longer have been submitted to state headquarters for special recognition at the annual dinner at French Lick Thursday night, October 30. They will receive lapel pins and certificates . . . Dr. E. M. Shanklin, completing fifteen years as editor of THE JOURNAL, will observe his birthday Friday, October 31.



Now . . . a brighter outlook for the child with petit mal

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No longer must the slow and uncertain processes of nature be depended on to bring relief to *petit mal* patients. Tridione—discovered and developed by Abbott Laboratories—offers the prospect of immediate improvement in the majority of cases. Here's further evidence added to the growing literature: In a recent investigation[1] Tridione was given to 166 patients suffering from *petit mal* (pyknoepilepsy), myoclonic jerks or akinetic seizures. None of the 166 had secured relief from any previous treatment. With Tridione, 31% became free of seizures; 32% had their seizures reduced by more than three-fourths; 20% improved to a lesser extent; 13% were unchanged, and only 4% became worse. *Thus 83% showed definite improvement.* In some cases the seizures *did not return* after Tridione was discontinued. Tridione has also been reported beneficial in certain cases exhibiting psychomotor seizures when combined with other anti-epileptic therapy.[2] Tridione is available through your pharmacy in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.3 Gm. per fluidrachm. If you wish literature, just drop a line.

1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiat., 103:162, Sept.

Abbott

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

August 8, 1947.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved for release:

Week of August 25, 1947—"Stuttering."

Week of September 1, 1947—"Body Changes with Age."

Week of September 8, 1947—"Cancer of the Breast."

A news story, entitled, "Heart Disease and Hay Fever Exhibit at Fair," was approved for release August 20 in daily and weekly papers.

A new caption for the "Hints on Health" column was okayed with deletion of the word "Indianapolis" from the artist's drawing.

An editorial from The Hammond Times, quoting from a bureau news release on swimming, was noted.

The bureau's report to the House of Delegates was accepted, providing it was satisfactory with the absent members.

BUREAU OF PUBLICITY

August 22, 1947.

President: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D. and Ray E. Smith, executive secretary.

Copy was approved for the following "Hints on Health" columns:

Week of September 15, 1947—"Warts on Soles."

Week of September 22, 1947—"Autumn Disease."

Week of September 29, 1947—"Undulant Fever."

The following general newspaper releases were approved:

Wednesday, August 27, 1947—"Pre-School Examinations."

Friday, August 29, 1947—"Medical School Scholarship Awards."

The American Medical Association radio transcription, "Keeping Your Baby Well," for use over WFBM beginning Monday, September 22, 1947, was selected.

Script for the program on "Hypertension," which the State Woman's Auxiliary Radio Committee will present over WFBM Monday, September 22, 1947, was approved.

A request from the Committee on Convention Arrangements for loan of the pictures of past presidents of the state association was taken under advisement. The bureau decided against permitting the originals to leave the headquarters office. The question of having copies made for the convention committee was debated, and a decision delayed until the Centennial Celebration Committee could be contacted for its opinion, and an estimate of the cost was procured by the executive secretary.

Preparation of an article about doctor supply in Indiana for the magazine *M D* was approved.

The executive secretary was directed to send a letter to Mrs. Frank W. Cregor in behalf of the bureau, thanking her for preparing the history of the Woman's Auxiliary to the state association.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. A. W. Ratcliffe, Evansville.

President-elect—Mrs. William Morrison, Kokomo.

Corresponding Secretary—Mrs. J. W. MacDonald, Evansville.

Recording Secretary—Mrs. Truman Caylor, Bluffton.

Treasurer—Mrs. Wendell Kelly, Anderson.

Press and Publicity—Mrs. F. M. Gastineau, Indianapolis.

OUR GOAL

"Every Doctor's Wife an Auxiliary Member"

President's Letter:

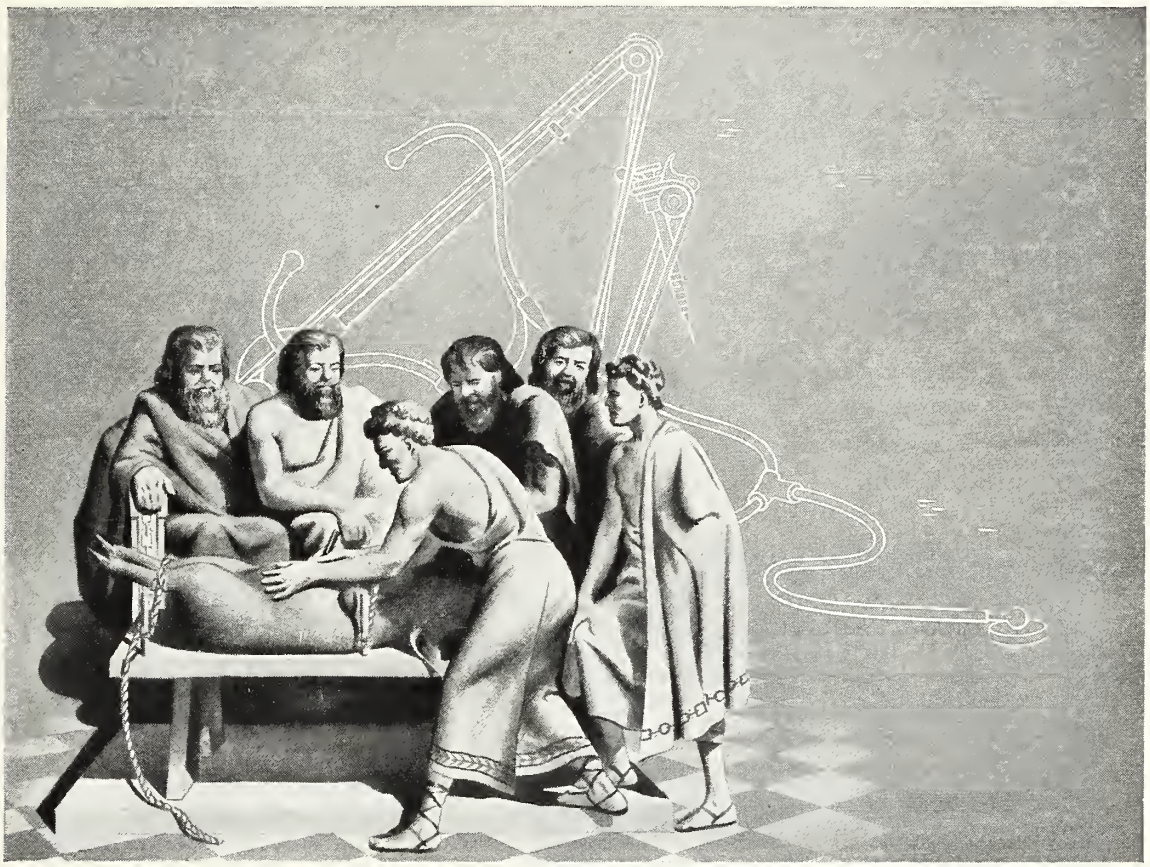
Hoosier doctors' wives are most cordially invited to attend the meetings especially planned for their entertainment at French Lick. The committee, of which Mrs. James W. Baxter, Jr., of New Albany is chairman, tells me that Dr. Hauss and his convention planning committee have gone to much extra effort to see that we have a wonderful time. (See Women's Entertainment Program in this issue.)

No morning meetings have been scheduled.

No long business sessions are planned.

For entertainment we urge you to be present at the frolic on Tuesday night with your husband. As you know, anything can happen at this time. On Thursday afternoon we will have a party. The prizes are "out of this world." A $50.00 CASH PRIZE WILL BE OFFERED SOMETIME DURING THE AFTERNOON.

Wednesday luncheon will be our first auxiliary meeting. During lunch it is possible that we may have a style show. This is not yet definite at the time of writing. We also hope to play the platters from our first state auxiliary broadcast over WFBM on September 15th. We know many were not able to tune in on this. After lunch we are trying something new in Indiana, a School of Instruction. To reduce the time and to provide smaller groups for discussion, we will break up into four sections. Groups of state officers and chairmen leading these sections will give brief talks (three to five minutes). Fol-



The First Experimental Physiology

For Both Medicine and Dentistry, the value of the first truly scientific dissections by Galen, the Greek who lived in Rome (130-200 A.D.), was equaled only by the scientific *method* propounded 600 years earlier by Hippocrates.

Working only with pigs and apes (but urging his students to be on the alert for human bones protruding from graveyards), Galen was first to recognize the different kinds of nerves, most muscles, the brain as the center of the nervous system and the fact that arteries, containing blood rather than air, were *somehow* connected with the veins (1500 years before Harvey).

A new concept of the doctor's legal liability was evolving then, too. Before, malpractice had been punishable only as a crime. But, under the *Lex Aquilia*, damages could be assessed. Malpractice had become a civil, as well as a criminal, offense.

There Are Few Who Experiment Today with the risks of unprotected practice. Most doctors enjoy the Medical Protective policy's *complete* coverage, *preventive* counsel and *confidential* service.

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INDIANAPOLIS Office: Kenneth W. Moeller, Representative, 1112 Hume Mansur Bldg., Telephone Riley 1013

lowing these talks the meetings will be thrown open for questions, suggestions, discussions, and exchange of ideas. EACH COUNTY AUXILIARY SHOULD HAVE AT LEAST ONE PERSON ATTENDING THE THREE SECTIONS—ADMINISTRATIVE, PUBLIC RELATIONS, and PUBLICATIONS.

Administrative sections for officers of county auxiliaries:

Leaders: Mrs. Charles F. Voyles, Parliamentarian; Mrs. S. L. Petronella, Councilor; Mrs. Wendell C. Kelly, Treasurer; Mrs. Truman Caylor, Recording Secretary; Mrs. J. D. McDonald, Corresponding Secretary; Mrs. Charles Wise, Finance Chairman; Mrs. C. D. Ehrman, Historian; Mrs. F. S. Cuthbert, Archives.

Public relations section for county committee chairmen:

Leaders: Mrs. B. W. Harris, Public Relations; Mrs. Lester Smith, Legislation; Mrs. D. E. Lybrook, Program; Mrs. Lyman Eaton, Radio.

Publications section for county committee chairmen:

Leaders: Mrs. F. M. Gastineau, Press and Publicity; Mrs. Milton Gevirtz, A.M.A. Auxiliary Bulletin; Mrs. Clifford Richey, Hygeia.

A fourth section, Organization, will follow a different plan. This group is for members of the auxiliary. We want to give you an over-all picture of auxiliary work and what it can mean to you. We are interested in forming new county units. This seemed a good time to talk things over.

Leaders: Mrs. W. R. Morrison, president-elect and organization chairman; Mrs. Charles Viney, first vice president and chairman northwestern district; Mrs. Maurice J. Thornton, second vice president and chairman northeastern district; Mrs. Leon Blum, third vice president and chairman southwestern district; Mrs. James W. Baxter, Jr., fourth vice president and chairman southeastern district.

Mr. T. M. Overley of the Indianapolis Better Business Bureau will speak on "Medical Quackery" at dinner Wednesday night. We guarantee that you will enjoy this talk. Dr. Romberger will be with us for a while at this meeting.

IT WILL BE A WHALE OF A CONVENTION. DON'T MISS ANY PART OF IT.

REBECCA RATCLIFFE, President.

P. S.—The Legislative Study Course which was promised for this JOURNAL will be published in our next *Hoosier Doctor's Wife*. This larger, printed edition of our new state bulletin should be in your mail box by October 15th.

Marion County

The Woman's Auxiliary to the Marion County Medical Society opened the fall season with a Garden Party honoring past presidents and new members, at the home of the membership chairman, Mrs. Morris B. Paynter, Roberts Road, 4700 South Meridian Street, Indianapolis, on September 23. Mrs. A. W. Ratcliffe was a special guest.

The following program has been arranged for the year:

November 18—Business meeting — luncheon — bridge at the Marott Hotel.

January 15—Legislative meeting and tea, L. S. Ayres & Co. Auditorium.

February—"DOCTOR'S DAY" Program.

March 4—Public Relations Meeting and a tea. Subject—"Know Your Health Department." Wm. H. Block Auditorium.

May 18—Spring roundup. Highland Country Club.

The Auxiliary has grown to approximately four hundred members, and our slogan is "EVERY DOCTOR'S WIFE AN AUXILIARY MEMBER."

Fern H. Bakemeier, President.

Vanderburgh County

Vanderburgh County Medical Auxiliary will open their year with a picnic in Old Heidelburgh Shelter House in Mesker Park on October 14th. Doctors' wives in neighboring counties are invited to be with the group. A special invitation has been issued to members of the newly organized Perry County Medical Auxiliary.

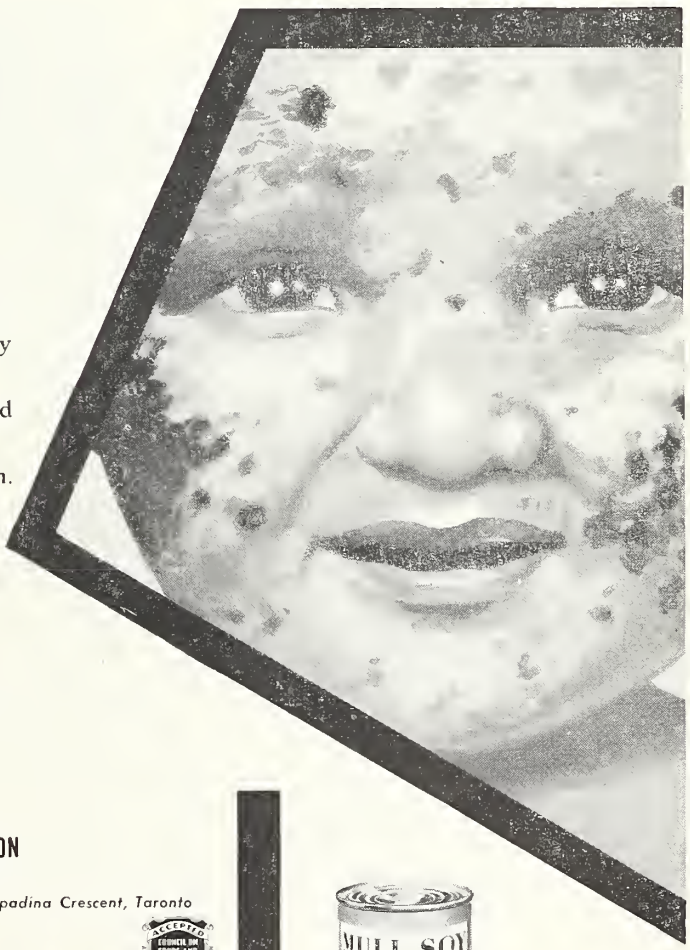
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for those **sensitive** to the proteins in milk . . .







• When children (infants and adults, too) are unable to tolerate the animal proteins in cow's milk, MULL-SOY—the emulsified soy concentrate—is the replacement of choice. It is highly palatable, and easily digestible, without the offending proteins of animal origin.

• MULL-SOY is a biologically complete vegetable source of all essential amino acids. In standard 1:1 dilution, it also provides the other important nutritional factors of fat, carbohydrate and minerals in quantities that closely approximate those of cow's milk.

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when milk becomes "forbidden food"

Books

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

INTERNAL MEDICINE IN GENERAL PRACTICE (Second Edition). By Robert P. McCombs, M.D., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. 741 pages, with 122 illustrations. Price $8.00. Cloth. W. B. Saunders Company, Philadelphia, 1947.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY (21st Edition). By W. A. Newman Dorland, M.D., Member Committee on Nomenclature and Classification of Diseases of the A.M.A.; Editor of "American Pocket Medical Dictionary." 1660 pages with 880 illustrations, including 233 portraits. Price $8.50. Cloth. W. B. Saunders Company, Philadelphia, 1947.

OFFICE TREATMENT OF THE EYE. By Elias Selinger, M.D., attending Ophthalmologist, Mount Sinai, Cook County and Michael Reese Hospitals. 542 pages. Price $7.75. Cloth. The Year Book Publishers, Inc., Chicago, 1947.

CONCISE ANATOMY. By Linden F. Edwards, Ph.D., Professor of Anatomy, Ohio State University, Columbus, Ohio. 548 pages with 472 illustrations, some in color. Price $5.50. Cloth. The Blakiston Company, Philadelphia, 1947.

INFANT NUTRITION (Fourth Edition). By P. C. Jeans, M.D., Professor of Pediatrics, College of Medicine State University of Iowa, Iowa City, and Williams McKim Marriott, M. D., Late Professor of Pediatrics, Washington University School of Medicine; Physician in Chief, St. Louis Children's Hospital, St. Louis. 516 pages with illustrations. Cloth. The C. V. Mosby Company, St. Louis, 1947.

OFFICE IMMUNOLOGY (Including Allergy). By Marion B. Sulzberger, M.D., Professor of Clinical Dermatology and Syphilology and Director, New York Skin and Cancer Unit, New York Post-Graduate Medical School and Hospital; and Rudolf L. Baer, M.D., Instructor in Dermatology and Syphilology, New York Skin and Cancer Unit, New York Post-Graduate Medical School and Hospital. 420 pages. Price $6.50. Cloth. The Year Book Publishers, Inc., Chicago, 1947.

MAY'S MANUAL OF THE DISEASES OF THE EYE. By Charles A. Perera, M.D., Assistant Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Assistant Attending Ophthalmologist, Presbyterian Hospital, New York. 521 pages with 387 illustrations including 32 plates, with 93 colored figures. Price $4.00. Cloth. Williams & Wilkins Company, Baltimore, 1947.

FUNDAMENTALS OF PSYCHIATRY (Fourth Edition). By Edward A. Strecker, M.D., Professor of Psychiatry and Chairman of the Department of Undergraduate and Graduate Schools of Medicine, University of Pennsylvania; Consultant and Chief-of-Service, Institute of the Pennsylvania Hospital; Consultant to the Surgeon General, U. S. Navy; formerly Consultant for the Secretary of War to the Surgeons General of the Army and A.A.F.; Senior Consultant in Psychiatry, Veterans Administration; Consultant in Mental Hygiene, U.S.P.H.S.; Chairman, Committee on Psychiatry, National Research Council, Committee on Psychiatry, American National Red Cross. 325 pages with 21 illustrations. Price $4.00. Cloth. J. B. Lippincott Company, Philadelphia, 1947.

SURGERY OF THE AMBULATORY PATIENT (Second Edition). By L. Kraeer Ferguson, M.D., Professor of Surgery, Graduate School of the University of Pennsylvania; Professor of Surgery, Woman's Medical College of Pennsylvania; Consulting Surgeon, U. S. Naval Hospital. With a Section on Fractures by Louis Kaplan, M.D., Associate in Surgery, University of Pennsylvania; Chief of Surgical Service II, Mt. Sinai Hospital; in Charge of the Fracture Division of the Surgical Out-patient Department, Hospital of the University of Pennsylvania. 932 pages with 645 illustrations. Price $10.00. Cloth. J. B. Lippincott Company, Philadelphia, 1947.

REVIEWED

A TEXTBOOK ON PATHOLOGY OF LABOR, THE PUERPERIUM AND THE NEWBORN. By Charles O. McCormick, A.B., M.D., F.A.C.S. Clinical Professor of Obstetrics, Indiana University School of Medicine, Indianapolis, Indiana. Cloth. Price $8.50. Pp. 514, with 272 illustrations. St. Louis: C. V. Mosby Company, 1947.

There has appeared on the book market a revised second edition of *A Textbook on Pathology of Labor, the Puerperium and the Newborn*, by Charles O. McCormick, M.D., which is worth investigating by all who practice obstetrics.

The concise and well-systematized mode of presentation eliminates pages of reading and yet presents clearly the principles involved. While some expressed thoughts on etiology and effect may at first thought seem somewhat farfetched, they are beneficial by their very provocative nature. The frequent historical comments relating to gradual development of present day obstetric art lend fascination, and the many references to obstetric literature provide a lead for additional information on subjects under discussion. The frank expression concerning accidents during delivery, poor judgment, and lack of experience are not at all embarrassing. The meditation invited by reading the many aphorisms is activated by the innovation of citing legal and religious dictates as they apply to the practice of obstetrics.

Consultation with the book is as stimulating as is an interview with the author, whose enthusiasm and energy are always contagious, hence a frequent "look see" is irresistible when the book is kept at hand.

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MONTHLY REPORT — JULY, 1947

Diseases	July 1947	June 1947	May 1947	July 1946	July 1945
Brucellosis	7	12	11	20	7
Chickenpox	27	122	268	55	55
Diphtheria	10	12	13	19	14
Dysentery (Bacillary)	1	2	2	0	0
Impetigo	3	5	5	0	4
Malaria	8	1	6	33	3
Measles	156	230	478	111	46
Meningococcemia	1	1	0	0	0
Mumps	22	52	97	56	58
Pertussis	220	153	171	103	127
Pneumonia	12	9	28	9	0
Poliomyelitis (Paralytic)	5	1	2	21	5
Rocky Mntn. Spotted Fever	5	10	3	0	0
Scarlet Fever	58	93	251	35	77
Septic Sore Throat	9	20	20	0	1
Tinea Capitis	13	29	13	0	0
Tularemia	1	1	1	0	0
Typhoid Fever	8	4	1	17	6
Vincent's Angina	1	1	2	0	0
Tuberculosis (Pulmonary)	191	197	220	124	196
Tuberculosis (Other Forms)	9	14	12	0	0
Meningitis (Menlngococcic)	5	1	0	0	0
Meningitis (Cerebrospinal)	1	5	3	5	12
Influenza	3	8	7	3	6

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—August, 1947

Diseases	Aug. 1947	July 1947	June 1947	Aug. 1946	Aug. 1945
Brucellosis	6	7	12	26	5
Chickenpox	32	27	122	21	20
Diphtheria	11	10	12	19	17
Diarrhea (Infectious)	4	...	...	...	...
Dysentery (Bacillary)	1	1	2	1	1
Food Poisoning	2	...	...	...	...
Impetigo	13	3	5	4	3
Influenza	1	3	8	2	17
Malaria	4	8	1	28	5
Measles	48	156	230	22	22
Meningitis (Meningococcic)	3	5	1	...	...
Meningitis (Cerebrospinal)	7	1	5	5	5
Mumps	10	22	52	26	37
Pertussis	252	220	153	100	135
Pneumonia	15	12	9	12	1
Poliomyelitis (Paralytic)	26	5	1	107	43
Rocky Mountain Spotted Fever	3	5	10	4	8
Rheumatic Fever	1	...	...	...	...
Rubella	2	...	3	2	4
Rat Bite Fever	1	...	...	...	...
Scarlet Fever	48	58	93	63	52
Septic Sore Throat	7	9	20	27	8
Tetanus	4	...	1	1	1
Tularemia	1	1	1	5	0
Typhoid Fever	28	8	4	13	5
Vincent's Angina	2	1	1	5	0
Tuberculosis (Pulmonary)	252	191	197	197	214
Tuberculosis (Other Forms)	7	9	14	12	6
Erysipelas	1	...	...	3	1
Poliomyelitis (Non-paralytic)	33	3	1	...	...

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Give him your complete confidence at all times and follow his recommendations.

Should he suggest a consultation with a fellow physician, or advise you to go to the hospital, you can be sure that such advice is based on his broad general knowledge of medicine plus his familiarity with your particular case.

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8	Frederick B. Wishard, M.D., Anderson	M. A. Austin, M.D., Anderson	Anderson
9	Milton W. Erdel, M.D., Frankfort	Claude D. Holmes, M.D., Frankfort	Frankfort, May 13
10	Neal Davis, M.D., Lowell	Frank G. Sink, M.D., Remington	October
11	Stephen D. Malouf, M.D., Peru	O. G. Brubaker, M.D., North Manchester	Wabash, May 19
12	G. T. Bowers, M.D., Fort Wayne	Karl M. Beierlein, M.D., Fort Wayne	
13	Ernest L. Dietl, M.D., South Bend	O. E. Wilson, M.D., Elkhart	South Bend, Nov. 12

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PRESIDENT'S ADDRESS*

FLOYD T. ROMBERGER, M.D.

LAFAYETTE

THE bell tolls the hour, the wheels of relentless time have revolved in a completed cycle, and it now is a full year since I last addressed the members of this great association in convention assembled. Much work has been done, and as is the custom I point with pride, but with a difference. I point not to myself; instead, I very happily and pridefully direct your attention to the achievements of the individual committeemen at the state level who so earnestly strove for you throughout 1947, to the virile efforts of our Council and its Executive Committee, and to the efficacy of our executive headquarters personnel.

A full accounting of all these accomplishments has been published in lengthy detail in the October JOURNAL and in the Handbook for the House of Delegates. The record speaks for itself. Read it. I commend it to your studious attention. It now is ready to be placed among the archives of your association, and I predict that the future medical history of this great sovereign state will give due credit for the progress made this year where that credit rightfully belongs, to our unified membership. For all this I join with you in a heartfelt testimonial of sincere approbation.

For more than thirty-eight years I have labored in the varied fields of organized medicine, plowing and readying the fertile soil, planting and sowing, cultivating and weeding, reaping and harvesting, just routinely following the directives of our so-fortunately able leaders, men wise through experience, each assigned task entirely unsought. Finally, two years ago the members of this association bestowed upon me their highest gift and trust; they honored me with the presidency.

Thus there has come to me over the many years a rich experience in organized medicine, pressed down and running over, and I would be totally unfaithful in my duty, and woefully would I belie the trust reposed in me if I did not at this time, most humbly and entirely unassumingly, attempt to give a terse brief of lessons learned the hard way over four decades.

I shall speak fearlessly and frankly, entirely impersonally, bluntly, concerning those organizational features which I believe sincerely to be for the future good of our beloved profession. I shall discuss only such matters to which I have given thoughtful study; I shall express my matured judgment, mellowed if you will, and I shall make suggestions. There will be no musts; they come from your House of Delegates through the truly democratic processes of free men.

Nor shall I prescribe hormones or vitamins or pink pills to be taken at bed-time as cure-alls for our organizational growing pains and our sometime headaches. That would be rank quackery. Rather, I bespeak for you still further sweat and continuing toil if we would retain that which we have and grasp that which we aspire. The many problems posed before your leadership often are bewildering in their ramifications, and the pressures and counterpressures are increasingly constant and constantly perplexing. They must be met head-on. Decisions must be made. Most fortunately, the pattern of wise principle is etched deeply, lies plainly before us, and its design is obvious to the clear-eyed. Details may be modi-

* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, on October 29, 1947.

fied or varied, yes; broad and fundamental principles remain inviolate.

I shall make three, definite, positive, and specific recommendations for ever-onward action now, at this session, looking beyond just today and anticipating still greater strength and stature for this, our already great association.

The County Societies

Of the many things which could be discussed regarding the constituent county societies, I wish to stress but the fundamental few.

Every county society should have 100 per cent membership and 100 per cent attendance. At all times the individual society should be in control of and be in a position to exercise discipline of that membership when necessary. This is vital. It denotes strength, a wise provision against the future. The principle is right.

The county society scientific programs, however good, and they uniformly are good, should neither be so heavy nor so numerous that the business aspects, the socio-economic problems of the society, are wholly obscured and relegated to utterly minor importance. I urge you not to neglect this. Sufficient time each month should be given or specific monthly meetings should be set aside for free and open discussion of the problems of state. This is just good business sense, and the principle is right. There is evidence that some of the constituent societies do not give due weight to this feature of organized medical activity.

Each county society should establish an undisputed lead in and a positive control of every aspect of medical care, however remote, occurring in its own county, both in and out of hospitals, at all times, rigidly, always in the greater interest of the public weal. This is forward-looking prudence, organized alertness, and the principle is right.

The county societies most carefully should choose their delegates to our state association in annual session. They should be elected from among their able members. Some should be young men. They should be instructed on their respective society's wishes. They should bring back to the society full and detailed reports on all activities and decisions of the House of Delegates. This is the democratic way, and the principle is right.

Every county society should accept the responsibility of seeing to it that never again will there be elected to the state General Assembly a single representative or senator who is unfriendly to physicians. I strongly urge the societies to convince and educate the electorate of their respective counties that the enemy of the physician is the enemy of the public, the enemy of the public weal, the enemy of democracy. This tenet is not unreasonable. So impress the vote-seeker, because he understands such language, and the principle is right.

The District Societies

I am not one who believes the utility of our District Societies passed on with the disappearance of the horse and buggy. These societies have a true function. Just as each county society has its problems which differ in part from its sister societies, so does each group or district. Also, from the districts come the Councilors, elected in the truly democratically representative way. The Council is your association's team of heavy draft horses; it pulls a considerable load. Your Councilor accordingly should be and must be informed upon and be responsible for the healthy activity of every county society in his district. Only then can the Council function wisely in your interest. This is basic, essential, and the principle is right.

The scientific presentations this year at the district meetings were very distinctly high grade. Each individual one was worthy of being heard by every physician in Indiana. The business sessions, mostly, could have been improved. The numerical attendance, with a few outstanding exceptions, left much to be desired. This a problem for the Councilors and for the respective society Presidents. The educative interest displayed by those members who were present at the district meetings was intense; they were there to learn, and they showed that they were. The social features were most pleasant.

A real and honest effort was made this year to carry to each district an epitomized story of the many activities being carried on by your great association; so that every district itself, each county society therein embraced, might be stimulated in its own organization efforts.

The Journal I.S.M.A.

This is truly your vital organ of scientific and organizational information. Its blood stream pulses and throbs with ever youthful vigor, and you have reason to be intensely proud of its achievements in 1947. Several new features were added throughout the year, making it still more outstanding; among others, the Year Book in January, Medical Panorama, and What's Going on in Indiana. I urge every I.S.M.A. member to read every page every month. The Editors and the Journal Publication Committee fully deserve your highest commendation. Tell them so! With sincere emphasis!

The House of Delegates

The House of Delegates of the I.S.M.A. is the business, legislative, and policy-forming body of your association. Adhering to the very fundamental principles of democracy, unlimited opportunity therein exists for every delegate freely to express the wishes of the members of his own county society on problems relative to affairs of importance at the state and national levels. The amalgamated and heat-tempered opinion of the House of Delegates, fused by free and open debate, rightfully is and should be the mandate to action for its duly elected representatives to the A.M.A. It is the obligation of the House so to instruct them. By parallel reasoning it is the bounden duty of our delegates to the A.M.A. to inquire

diligently and seriously into, and very definitely to determine this solidly welded thought of our House of Delegates and of our membership at large throughout this sovereign state. This opinion must be absolutely impersonal, its objectives clear, and it must reflect the majority sentiment of the I.S.M.A. It is only in this flesh-and-blood democratic way that organized medicine can answer the pointed shafts leveled at us by a part of the lay press, and by the Congress and in the committee rooms thereof, that our official spokesmen at the national level do not represent the major body of thought of the actively practicing physicians of America. Justifiable criticism or not, if there be fault it is not with organized medicine's democratic representation; but rather the indictment points toward lethargic lapse and *laissez faire*, and toward the intrusion of personalities. We then dismally have failed to make democracy work. Personalized control, by fiat or edict or autocratic rule or unwarranted assumption to speak for the masses, kills democracy. A dead corpus suffers no headaches; that we have headaches signifies life and living, perhaps; and we still can hope that it spells progress. Let us heed the lessons. Beware of *l'etat, c'est moi*, the state it is I, be it in government or be it in organized medicine. America is different.

Medical Education

I suggest that every individual physician, every county and district society, every hospital staff, and our great association, all should organize themselves into a multitude of intensely active nuclei of instruction in medical practice at the undergraduate and graduate levels. Each can be and should become a spreading focus of instructional infection. In this direction lies progress. The need is greater year by year. An educational chain reaction could be set off lasting for generations to come. The principle is right.

I cannot urge too strongly the unification of Indiana's four-year course of instruction for medical students as a single, revitalized, composite unit upon the Medical Center campus of our capitol city. The prerequisites, the precedents, and the benefits all are obvious, and the basic principles are sound. In this endeavor let us learn by our failures of the past. Wishful thinking, polite letters and verbal charms, incantations and resolutions and mere committee effort, all have proved futile. We can stop the itching by doing more scratching! Heat and pressure applied by a statewide-aroused profession, every member grubbing and spading and working and sweating, are needed instead of some as yet elusive, magic formula. Sufficient heat and sufficient pressure will mold anything.

Inconsistent and paradoxical as it may seem, many Indiana physicians who are not graduates of our state university most creditably are far more alert toward and display greater interest in this matter of undergraduate medical instruction than some of that institution's own alumni. These need an activity-stimulating cerebral virus.

Millions of dollars must be provided; for buildings, for facilities, for full-time heads of departments, for research. The Indiana General Assembly, justly proud of its state roads and recreational facilities and parks and conservation practices, and of our superior corn and hogs and cattle, still regards with miserly niggardliness the production and training of more and better physicians to care for its citizenry. This with a multimillion surplus of cash on hand! What a complex!

Public Relations

This subject, both at the county and at the state levels, seems by some to be shrouded in the fogs and mists of doubt and misunderstanding; whereas, as a matter of fact, the problem is quite simple if we would but think it through clearly, each I.S.M.A. member personally. It is not entirely a question of mass action; it also and importantly is one of individual behavior and responsibility. An altimeter and radar will let you down safely to earth from your psychic stratosphere.

Like it or not, from the moment that you begin to practice medicine your entire life is out in the open, subject to public scrutiny and opinion. Your own individual behavior pattern fixes the public's judgment of your value in relation to the organized social scheme and the essence and science of living as we at present understand and exercise it. Remember this: The good which is done by the many is overlooked; the whole of us are penalized by the evil which is wrought by the few.

Study that philosophy. Carry through with that principle at both the county and state levels; then I am sure that you will conclude as do I that we create, both as individual physicians and as a group, our own public relations. By virtue of the public's estimate and evaluation we either draw dividends of esteem, or we are handed blank checks of notoriety, each to write what he would. We either flower approval or we breed adverse criticism. Every one of you may sketch in the details of your own, all-too-plain, general pattern. I pose but one additional thought before you: A generation ago physicians were looked upon almost with reverence; today we hire experts in public relations! Why?

Random Comment

The establishment by the Council of a Scholarship Trust to aid worthy medical students and student nurses to complete the necessary requirements to gain their respective degrees was a most worthy objective attained during the current year. It speaks loudly of the Council's composite wisdom and judgment. Many details necessarily were elaborated by the Committee on Medical and Nursing School Scholarships. They worked hard! Their efforts deserve your every commendation. I advise that full publicity be given throughout every county

in the state to this very fine feature of your association's activities. This is most excellent public relations.

The directive by the Executive Committee to THE JOURNAL to furnish greater white space for their news items, and the earmarking by the Council of certain modest funds to aid the Woman's Auxiliary in its organizational efforts, both were concurrent moves in the right direction. The Auxiliary is deserving of our full support. Dividends will become available to us through their co-operative help and spirit. The principle is right, forward-looking.

Throughout the year most cordial relations were established and maintained with the press, with the members of the Indiana General Assembly, with all allied and related health bodies, and with organizations which have to do with the betterment of the medical care of the citizenry of this sovereign state. Full credit for this is due to the skill and the finesse with which the executive details were carried out under the direction of your officers and of the respective committees in charge. Your association continued to grow throughout 1947, both in honor and in esteem. I urge that these activities be continued.

A review of the lessons learned by the state and county legislative committees during the year past leads to the profound conviction that one or more of our I.S.M.A. members could and should stand for election and serve as a representative or senator from his respective district. There is a crying need for such service. The pay is reasonable for the time involved, and the opportunity for doing good for the physicians of Indiana and for the safeguarding of the public weal is without parallel. I strongly urge the county societies to give this problem their most earnest thought. This is practical and sound technique.

Full publicity throughout the state should be given to the fact that the physicians themselves were willing to pay an annual registration fee, so that their own funds might become available to protect the public weal from the imposition upon Indiana's citizenry of charlatans, quacks, and illegal practitioners bogusly attempting the healing art. This is good judgment.

For the first time in its history the A.M.A., this past June in Atlantic City, held a round-table discussion on county medical society problems for all the secretaries of the duly organized county societies in the United States. This was commendable. The principle is right. The session was and can be maintained and be further developed as a truly democratic process, because these secretaries are properly elected representatives from the constituent societies. In the event that this feature is continued year after year, I strongly am of the belief that the usual travel and hotel expenses of these secretaries, so in attendance, should be borne by the respective societies. I also hold the thought that the expenses of the several delegates from our own county societies when in attendance at our annual state meeting should be paid by the societies they then and there represent. There is sound reasoning back of this: The society then would have a real vested interest in its representative being there properly to function on its behalf, and the delegate readily might feel a greater sense of obligation to return to his society better dividends on its investment in him. The principle is right.

In honoring those of its members who have been in practice fifty years or more, the I.S.M.A. honors itself. This is good public relations, a happy thought.

Our physician-sponsored Mutual Medical Insurance, Inc., made phenomenal growth in 1947. The lusty baby developed into vigorous adulthood. This association activity, too, is favorable public relations.

I suggest that our headquarters offices be enlarged and rehabilitated. They no longer fully are in keeping with the prestige of our great association. We have outgrown them. We need more space, more comfort, and more convenience for truly operational efficiency. Here, indeed, is the focal point of the activities of our association. Here rightly may and rightly should come any and every member of the I.S.M.A. for help in his professional problems. And, too, they are getting it there. Here also meet the many state committees. Here are held official conferences, quite a few with heads or representatives of allied bodies at the state level. Our official "front" at 1021 Hume Mansur Building is not of the best and leaves much to be desired. Admittedly the problem is one for your Council and its Executive Committee, but it is mentioned here so that the I.S.M.A. membership-at-large, if they so desire, themselves may needle the hypodermic stimulations.

In this connection it is my mature thought that the time has arrived when the I.S.M.A. could and should occupy its own headquarters building. We possess the necessary financial resources. Sound busines acumen dictates that desirable locations, good buildings, worth-while property, and gilt-edged investments exceedingly seldom come into distress markets at five-and-ten prices, be the times good or be they bad. This admits little controversy.

The amount of work carried on by the members of your Executive Committee and your Council is enormous. Frequently their sessions stretch into five and even six continuous hours. I suggest that you give this your thoughtful consideration and afford them some easement. I would advise that every letter to them of more than a page, every committee report, every resolution, and every petition or proposition when presented to them individually, be accompanied by concise memorandums, a digest as it were; so that the necessary definitive action could be determined almost at a glance. This is not with the idea of choking off

debate or limiting full discussion. Rather, it would facilitate such consideration, this by saving time for these busy physicians in the proper evaluation of each particular problem, and also by averting unnecessary duplication of effort by these two bodies. This is just orthodox executive efficiency.

Woman's Auxiliary

This year the Woman's Auxiliary celebrates its silver anniversary. Congratulations are in order. I now and herewith extend such felicitations on behalf of our association.

Over the years the ladies have labored with many odds and some handicaps against them. These obstacles are not insurmountable. Willy-nilly, our auxiliary is part and parcel of our organized medical profession; its members are married to us; we should work together in a truly beneficent family relationship, they accepting us, we them. Let's not tear up the lottery ticket. It could be a winner! A rather intimate acquaintance with and several reports received from over the state point to the thought that at local levels certain of the auxiliary constituent branches have encountered difficulties in navigating the shoals of trivialities and in finding the true channel between the out-jutting rocks of personalities. Much advantage could accrue to us through our aid to them in the proper charting of these hazards. I charge every district Councilor and every county society President to give a helping hand to the auxiliary in his respective area; for our auxiliaries can be of expanding usefulness as they continue to grow in strength and vigor and influence by presenting true and factual data, entirely impersonal, keeping in mind most clearly only the betterment of medical care for all the people, this before the many ladies' groups with which they are affiliated. I so predict. The principle is right.

Recommendations

The routine functions and labors and the many essential contacts and necessary visitations of the official family at the top-flight level of your association have grown by prodigious leaps and bounds over the years. Therefore, after mature study and thoughtful deliberation, based upon many years of acquaintance with the internal machinery of our great organization, I make the three following, forward-looking recommendations for action now, at this session:

1. I recommend that the official family of our association be enlarged by the addition of a Vice-President. This incumbent should be elected annually by the House of Delegates to serve for the ensuing fiscal year. He should be an actively practicing physician. He should not be eligible to become President-Elect during the year of or the year following his holding this office. His duties should be to assist the president and to succeed to that office only upon the death or resignation or removal from office of that officer. A Vice-President could be a great help to the President, and hence to the association, in aiding in the routine visits to the district and county societies and by appearing before and consulting with the many allied health bodies in his geographical area, also in presiding at some of the scientific sessions and being present at section meetings during our now enlarging annual conventions.

2. I recommend that the official family of our association be enlarged by the addition of a Speaker of the House of Delegates. He should be an actively practicing physician with large acquaintance and proper esteem over the entire state. He should be elected annually by the House of Delegates to serve for the ensuing fiscal year. He should not be eligible to become President-Elect during the year of his service or the year following, but should be eligible for re-election as Speaker from year to year if willing and if found worthy. He should be well-versed in parliamentary procedure, commanding at all times the respect of the House. Previous service therein would be an asset. His duties should be to preside over the House of Delegates whenever it is in session. He thus would aid the president by relieving him of that part of the load; and the House of Delegates, through its own selective action, always would have future assurance of capable executive chairmen. In consultation with the President and with the Executive Secretary, the Speaker should be responsible for the organization of the House, especially with regard to the presidentially appointed reference committees.

3. I recommend that both the city and the exact date for the annual convention of our association be selected by the House of Delegates two years in advance. This markedly would facilitate the work of and give greater flexibility in certain arrangements relating to the convention, those now routine in our executive headquarters.

The advantages accruing to our already strong and vigorous association through these recommendations readily are apparent if given proper study and mature thought. They conform in all respects to sound executive essentials. They are in harmony with every experience. I strongly recommend and even urge their adoption now, at this session. The principles are right.

Inasmuch as changes in both the Constitution and the By-laws are needed to implement these recommendations, I suggest that the now President-Elect be authorized to choose a committee properly to formulate these provisions, so that the committee may become fully activated and begin to function early in the coming year. It will be necessary to publish the completed text of change and addition twice in The Journal in 1948. Then, that Fall, again in annual session, the House of Delegates can give approval; so that in 1949, our Centennial year, our still more solidly

organized official family, and indeed our entire I.S.M.A. membership, may function to the best and highest advantage of our great Indiana State Medical Association.

I further suggest that this committee take under consideration an exact and specific line of succession in the event of vacancy in the offices of President, President-Elect, Vice-President, or Speaker. At present this feature of succession is not clear; for example, none is provided for in the event of vacancy of the office of President-Elect. The wisdom of all experience dictates that these four offices at all times should be held by actively practicing physicians duly elected by and responsible to the House of Delegates. That is democracy at work.

In Conclusion

I bow with the deepest respect before the greatness of the Indiana State Medical Association. It is rugged. It is strong. It is sturdy. I do not criticise. I know what its trials and tribulations have been—and are. The thoughts and suggestions and recommendations of this address have come to me only through long and intimate working contact with many sound and well-balanced medical minds throughout this great sovereign state, worth-while men, good physicians, wise leaders, all joined in a common purpose: That the Indiana State Medical Association shall continue to grow in honor and influence and prestige, and even in majestic grandeur, as the years roll on and on and on.

BUNDLE BRANCH BLOCK OF THE BROAD S TYPE*

Report of Eleven Cases Without Any Evidence of Heart Disease With One Instance Showing Partial and Transient Block

Captain Charles Fisch, MC-AUS†

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THE following report deals with eleven consecutive patients, seen in a period of ten months, all of whom exhibited an abnormality of the electrocardiogram characterized by a prolonged (.11 seconds or longer) QRS complex. The extra width of the QRS complex is due to a broad S wave. This S wave is best demonstrated in Lead I, although Lead II may be practically indentical with Lead I. Lead III does not follow any definite pattern. QRS in CF-1 and/or CF-2 is polyphasic, or notched, while the apical lead usually follows Lead I. Wilson[1] and his co-workers, experimenting with serial precordial leads in human beings, were able to show that this pattern, previously not fully understood, was due to a block of the right bundle. Their work is now generally accepted as being conclusive.

As early as 1925 Oppenheimer[2] and his associates drew our attention to the favorable outlook of some of the patients exhibiting the broad S pattern. Their observations were supported by reports by Von Deesten[3] and Wood[4] and his associates. The latter divided their series of 64 cases into 4 groups, depending on the severity of the underlying cardiac pathology. They came to the conclusion that not only do the individuals exhibiting the broad S pattern have a proportionately smaller percentage of heart disease than the literature on bundle branch block would lead one to suspect, but also that this type of bundle branch block per se does not alter the gravity of prognosis. The prognosis appears to be dependent almost entirely on the underlying heart pathology. At present the general consensus is that the bundle branch block of the broad S type is compatible with a long life and the presence of nonprogressive heart disease.

This entire subject is excellently reviewed and organized by Willius, Dry and Reeser.[5] Their

* Published with permission of the Medical Director, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the author.

† Veterans Administration Regional Office, Indianapolis.

[1] Wilson, F. N., Johnston, F. D., Ian, G. W., Hill, M. B., Macleod, G. A., and Barker, P. S.: The significance of Electrocardiograms characterized by an abnormally long QRS interval and by broad S-deflection in Lead I. *Am. Heart J.*, 9:459-470, 1934.

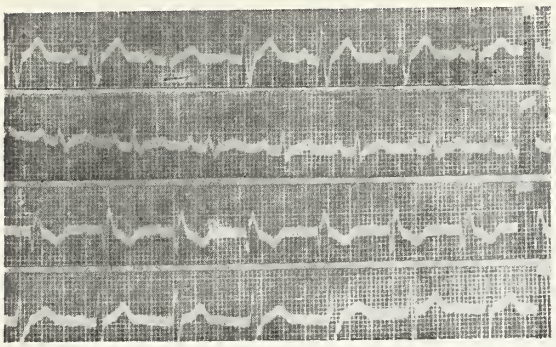
[2] Oppenheimer, B. S., Rothschild, M. A., and Mann, H.: Cardiographic differentiation of a sub-group of intraventricular block with observations on the prognosis. *J. Clin. Invest.*, 1:592, 1925.

[3] Von Deesten, H. T., Dolganos, M.: Atypical bundle branch block with a favorable prognosis. *Am. J. Med Sc.*, 188:231-235, 1935.

[4] Wood, F. C., Jeffers, M. D., Wolferth, C. C.: Follow-up study of sixty-four patients with right bundle branch block conduction defect, *Am. Heart J.*, 10:1056-1065, 1935.

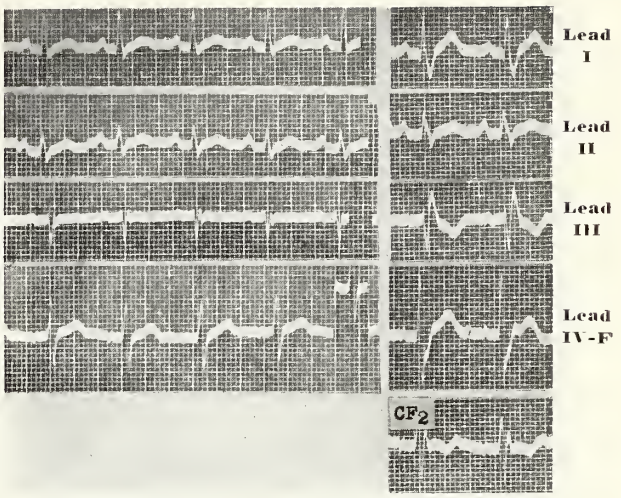
[5] Willius, F. A., Dry, T. J., Reeser, R.: Life expectancy in conductive disturbances affecting the ventricular complex of the electrocardiogram.
I. General consideration of bundle branch block with concordant and with discordant graphs and the wide S pattern, based on 1611 cases, *Arch. Int. Med.*, 67:1008-1026, 1941.
II. Special consideration of the wide S pattern, with report of three cases, *Arch. Int. Med.*, 67:1034-1049, 1941.

FIGURE I



Tracing obtained from patient I (August 20, 1945), showing partial bundle branch block of the broad S type. Note the normal ventricular complexes in Leads I, II, and IV-F.

FIGURE II



A B

Patient I. Tracing A was obtained on September 5, 1945, and reveals no abnormalities. Tracing B was obtained October 9, 1946, and shows complete right bundle branch block of the broad S type.

studies brought out some interesting facts regarding this problem: (1) In 14 instances in which the S type of conduction defect developed while the patients were under observation there was nothing to indicate the cause in 8 of them; (2) Out of a total of 492 individuals exhibiting this abnormality etiological diagnosis was not determined in 144 instances. In conclusion, the authors state, "In the case of the last named group, namely, that with the S pattern, the course is by far the most favorable. The highest mortality occurs during the first year after the discovery of the lesion (20 per cent). After this the annual death rate drops so that life expectancy curve tends to parallel that of normal population. After S pattern has existed for ten years, more than a third of the patients are still alive. This is especially significant when it is remembered that the average age of the patient at the time the lesion is discovered is almost 60 years."

The fact that in all of the following reported cases there were no symptoms or signs indicative of heart disease, and the ECGs were taken as a matter of routine procedure, prompted us to report this series. The author would like to impress on the reader the relatively early age at which some of these abnormalities were discovered. It is hoped that this study will add to the understanding of this problem.

Case Reports

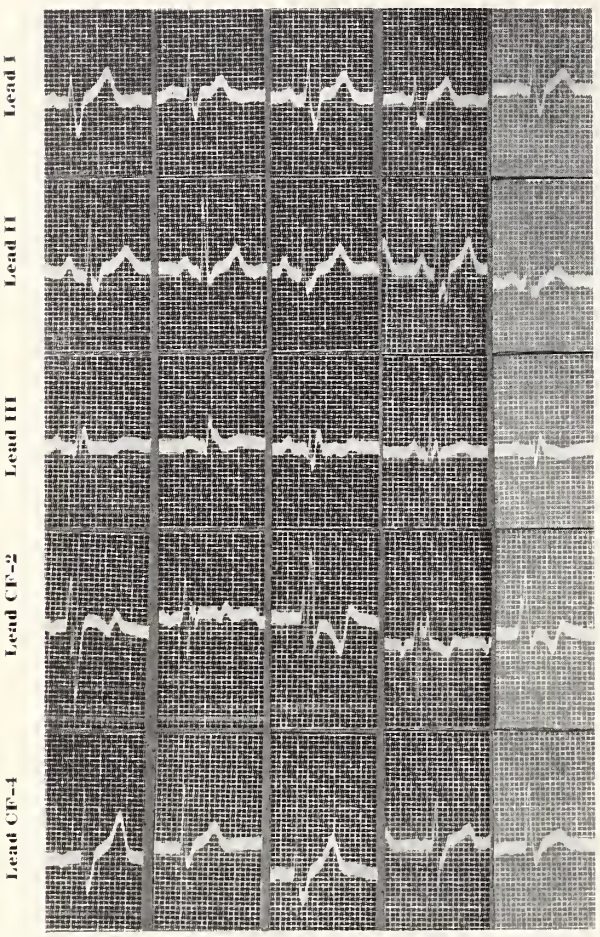
Case 1. M.D., a 32 year old, white male, was in good health until June, 1945, at which time he began to complain of palpitations, dizziness, and nervousness. A diagnosis of neurocirculatory asthenia was made. An ECG taken August 20, 1945, revealed partial bundle branch block of the broad S type (Fig. 1). The same abnormality was found again on August 28, but since that time repeated ECGs were normal (Fig. 2A), and the man was discharged from the service. He was re-examined October 9, 1946. His complaints were indentical with those present when he was first hospitalized in June, 1945. Physical examination showed an obese white male, height 66", weight 212 pounds, BP 130 systolic and 86 diastolic. The rest of the examination, including fluoroscopic study of the chest, was negative. An ECG revealed the presence of a complete right bundle branch block of the broad S type (Fig. 2B).

Case 2. (Fig. 3A) A.B., a 22 year old, white male, a farmer, was in excellent health until January, 1945, at which time he was injured in combat and suffered gunshot wounds in both hands. During his hospital stay he developed a mild infectious hepatitis. A routine ECG revealed the broad S pattern. When examined, on August 6, 1946, the man was entirely asymptomatic; BP 140 systolic and 84 diastolic; physical examination was negative; ECG showed the presence of the broad S pattern.

Case 3. (Fig. 3B) I.L., a 31 year old, white male, a laborer, was perfectly well until April, 1945, at which time he developed a marked anxiety state. Shock therapy was considered and during a preliminary medical work-up a routine ECG revealed the presence of the broad S pattern. Otherwise the study revealed nothing of note. The patient's physical status was found to be essentially the same when the patient was examined in September, 1946.

Case 4. (Fig. 3C) M.S., a 37 year old, white male, a liquor store clerk, was perfectly well until May 1945, at which time he reported to a Naval hospital complaining of nervousness, loss of weight, and poor appetite. Physical examination revealed a tachycardia, fine tremor of his

FIGURE III



Bundle branch block of the Broad S type (right). QRS complexes measure .12 seconds or more. Prominent S waves are seen in Leads I and II. The pattern of the QRS complexes in Lead III varies in shape. Note the characteristic splintering of the QRS complexes in Lead CF-2. The above tracings were obtained from patients II, III, IV, V, and VI.

fingers, and sweating of palms of his hands. A tentative diagnosis of hyperthyroidism was made, but a complete study failed to confirm the working diagnosis. ECG revealed the presence of the broad S pattern. The man was re-examined October 19, 1946. At that time he complained of weakness and nervousness. Complete physical examination, with fluoroscopic study of the heart and B.M.R., was negative. ECG showed an abnormality identical with that found in May, 1945.

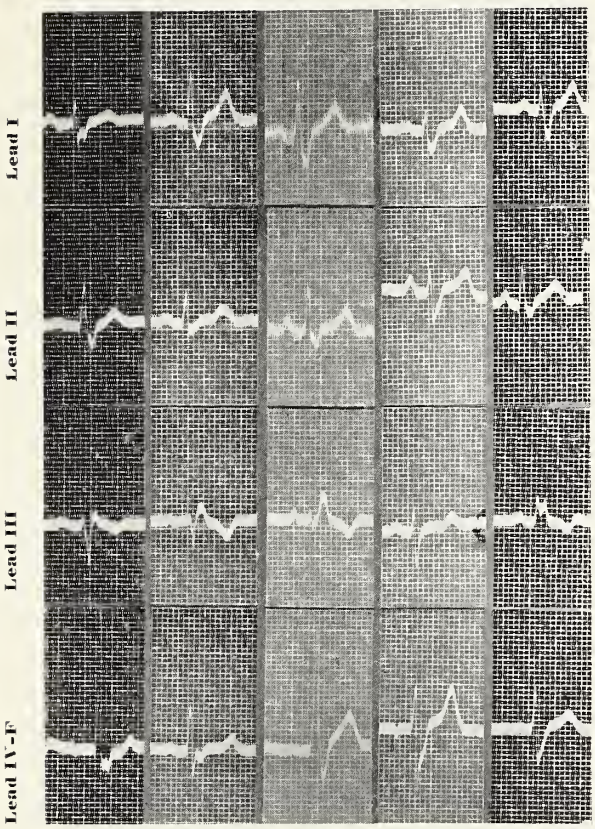
Case 5. (Fig. 3D) F.K., a 20 year old, white male, became ill with a cold on December 9, 1945. This initial illness was complicated by scarlet fever. On January 1, 1946, he again developed a sore throat which was followed by migrating polyarthritis, and a diagnosis of rheumatic fever was made. The man had elevation of temperature, but repeated sedimentation rates were all normal. ECG taken on January 20, 1946, was read as showing ". . . myocardial damage. Intraventricular conduction disturbance. Tendency to right axis shift." A grade I systolic murmur was heard along left sternal border on January 25, but the murmur was transient in nature. The hospital course was uneventful and the man was separated from service April 18, 1946. The patient was re-examined on March 31, 1947, at which time no abnormality of the cardiovascular system was noted, except for the presence of the broad S electrocardiographic pattern.

Case 6. (Fig. 3E) V.M., a 27 year old, white male, a deep sea diver, was examined for compensation purposes because of arthritis of the right knee. Past history revealed that in 1936 the man suffered a fracture of the right patella. He enlisted in the Navy in 1943 and followed his occupation of a sea diver. In January, 1945, he noticed increasing pain in the right knee. An ECG was taken prior to surgical repair of the patella which revealed a bundle branch block of the broad S type. He appeared before the Naval Medical Survey Board and was separated from the service because of arthritis, traumatic, right knee. In discussing the ECG abnormality it was the opinion of the board that the ECG changes were not fully understood and therefore could not be taken as evidence of myocardial damage. After separation from the service the man returned to deep sea diving and later enrolled in engineering school. Physical examination performed on April 1, 1947, revealed no abnormalities of the cardiovascular system. The ECG showed right bundle branch block of the broad S type.

Case 7. (Fig. 4A) I.M., a 57 year old, white male, reported to a Veterans' Administration Hospital November, 1944, for an examination for retirement purposes. His complaint at that time was a constant dull ache in the region of the left pectoral muscle group. The pain had no relation to exertion. A complete physical examination was negative except for the presence of a soft systolic blow at the apex. Routine ECG revealed the presence of the broad S pattern. The man was re-examined on November 15, 1946. His complaint was indentical with the one given during the first examination. Physical examination failed to reveal any abnormality except for a moderate arteriosclerosis. BP 145 systolic and 80 diastolic. The ECG revealed a broad S pattern.

Case 8. (Fig. 4B) S.C., a 66 year old, white male, reported for a physical examination on December 16, 1946. His complaints were myriad and implicated practically every system of the body. A review of the man's records revealed a number of previous hospitalizations (1932, 1936, 1940, 1944). During his stay in a hospital in May, 1937, a routine ECG revealed the presence of right bundle branch block of the broad S type. Physical ex-

FIGURE IV



Case VII Case VIII Case IX Case X Case XI

Tracings obtained from patients VII, VIII, IX, X, and XI. The electrocardiographic pattern is the same as described under Figure III. Lead CF-2 was not obtained in these five patients. The prominent Q wave and inverted T wave in Lead III, when associated with right bundle branch block of the broad S type should not be considered as being indicative of coronary sclerosis.

amination performed on December 16, 1946, was negative except for moderate arteriosclerosis; BP 140 systolic and 80 diastolic. The ECG showed a pattern indentical with the one first discovered 9 years and 10 months before.

Case 9. (Fig. 4C) H.H., a 21 year old, white male, a farmer, appeared for a cardiovascular examination on January 13, 1947, because of discovery of premature beats during a physical examination prior to the man's separation from the service. The patient stated that as far as he knew he was in excellent health. Past history was noninforming. Physical examination revealed a well-nourished and developed white male of stated age. BP 120 systolic and 80 diastolic. The entire examination was negative except for occasional premature systoles. A routine ECG disclosed a bundle branch block of the broad S type.

Case 10. (Fig. 4D) I.M., a 60 year old farmer, was examined in the Out-Patient Department of the V.A. on March 21, 1947, because of recurrent dislocation of the right knee. The patient's past history and complaints were limited to his right knee. Physical examination revealed a well-developed and well-nourished white male of stated age. The right knee was swollen, tender, and there was a limitation of extension and flexion in that joint. A routine ECG revealed the presence of bundle branch block of the broad S type.

Because of this finding the man was referred to the cardiovascular section. The blood pressure was found to be 140 systolic and 80 diastolic. There was moderate peripheral arteriosclerosis, but otherwise the cardiovascular system was considered to be normal.

Case 11. (Fig. 4E) S.T., a 31 year old, white male, developed diphtheria February, 1946. He was treated with diphtheria antitoxin and made an uneventful recovery. An ECG taken on the third day of the man's illness disclosed the presence of the broad S pattern. This pattern persisted without any demonstrable change. The man was re-examined on February 20, 1947, at which time his cardiovascular system showed no abnormality except for the presence of ECG evidence of right bundle branch block of the broad S type.

Comment

Each one of the patients was studied very carefully, with two thoughts in mind. It was desirable to determine the etiology of the lesion and, as a direct result of that, to be able to determine the prognosis of the patients with the broad S electrocardiographic pattern. As one can readily see, the determination of these two factors has a great bearing on the amount of compensation which the Veterans' Administration would have to pay the veteran. A review of the literature regarding the prognosis for life was quite confusing, different ideas being expressed by different authors. The few and widely scattered early optimistic reports regarding the broad S pattern[2,3,4] were not generally accepted by the medical profession. However, more recent studies have shown that many of the electrocardiographic patterns, which in themselves were thought to carry a grave prognosis, have a prognosis no worse than that of the underlying cardiac pathology. This was brought about by a more widespread use of the electrocardiogram in young and apparently normal individuals. The above statement is quite applicable to the broad S electrocardiographic pattern.

Needless to say, the attempt at making an etiological diagnosis in the patients under discussion met with failure. Some of the patients were young enough so that congenital origin of the conduction defect was considered very seriously, but this could not be proved beyond any shadow of doubt.

TABLE I

Case	Age at which the BBB was First Discovered	Period During which the Lesion was Known to Exist	Reason for Taking the Original ECG	Abnormalities of the C-V System
1	31	20 months	N-C-A	none
2	20	26 months	gun shot wounds hepatitis (routine)	none
3	30	24 months	shock therapy (routine)	none
4	35	22 months	hyperthyroidism (not confirmed)	tachycardia
5	19	17 months	rheumatic fever	no residuals
6	26	17 months	surgery (routine)	none
7	55	29 months	pain in left chest	moderate arteriosclerosis
8	56	9 years, 10 months	myriad complaints (routine)	moderate arteriosclerosis
9	21	2 months	premature beats	premature systoles
10	60	2 months	dislocation of knee (routine)	moderate arteriosclerosis
11	30	12 months	diphtheria	none

It was not felt that there was any justification in assuming that the conduction defect in some of the individuals was due to coronary sclerosis, just because they happened to be in the age group in which this disease predominated. For as Katz stated, in discussing this problem as related to a 50 year old patient of his in whom the broad S pattern was the sole finding, "It may have been congenital in origin or due to coronary sclerosis. In the latter event, it was the sole evidence of this state, the coronary disease being otherwise occult or benign."[6]

In patient 5, in whom the conduction defect was discovered during a bout of rheumatic fever, the latter can theoretically be accepted as the etiological agent. However, the lack of a normal ECG prior to the onset of rheumatic fever and the absence of other ECG findings during the active illness, characteristic of rheumatic myocarditis, such as prolongation of the P-R interval, leaves the etiology in this case, as in the rest of the patients, a mere speculative matter.

In patient 6 the conduction defect was discovered during an attack of diphtheria, but again the lack of electrocardiographic tracing prior to onset of the illness, coupled with the well-established fact that diphtheria leaves no residual myocardial damage in patients who recover from the illness, led the author to the conclusion that the broad S pattern was a coincidental finding and was not a result of diphtheria.

A few rather interesting observations were made during the study of this series. These are as follows:

(1) Absence in all of the patients of any signs or symptoms suggestive of heart disease.

(2) The average age of the patients, when the lesion was first discovered, was 35 years, as compared with almost 60 for the group reported by Willius, Dry, and Reeser.

(3) In four of the individuals (1, 2, 4, 8) a diagnosis of coronary sclerosis was made on the basis of the electrocardiographic findings alone.

(4) One of the patients (1) developed the broad S pattern while under observation without any discernible cause. His first ECG showed partial right bundle branch block which returned to normal in three weeks, only to reappear as a complete block.

(5) In nine of the patients the duration of the lesion, from the time it was first discovered, exceeded 12 months which, coupled with absence of any demonstrable heart disease, is compatible with a normal life span and the presence of nonprogressive heart lesion. This assumption is based on the studies of Willius, Dry, and Reeser.[4]

The discrepancy between the average age of our group, as contrasted with that of Willius, Dry, and Reeser, can be explained by the fact that in our series the ECG was used more or less as a routine procedure regardless of whether or not the primary disease for which the man was hospitalized was cardiac in origin. Were the electrocardiographic abnormalities first discovered at a time when manifestations of some subsequently developed heart disease first occurred, the average age for the same group would be much higher, and the prognosis of the bundle branch block per se would be no better than that of the associated cardiac pathology. This fact would necessarily tend to distort the statistics regarding the prognosis and etiology of bundle branch block of the broad S type. In view of the present knowledge regarding the broad S pattern, the author feels that a diagnosis of coronary heart disease based solely upon the presence of this pattern is unfair both to the patient and the Veterans Administration. The former may become a cardiac invalid for the remainder of his life and the latter is forced to pay compensation out of proportion to the existing cardiac abnormality. A more widespread use of the electrocardiogram in normal children and young adults will lead to discovery of this pattern at its inception or as close to it as possible. This, when coupled with an adequate follow-up period,

[6] Katz, L. N.: *Exercises in electrocardiographic interpretation.* Lea and Febiger, Philadelphia, 1946, p. 114.

may give us the answer regarding the etiology and clinical importance of the broad S pattern.

The medical department of the Veterans Administration, with its tremendous volume of material and an ideal chance for follow-up studies, can add greatly to the understanding of this problem.

SUMMARY

(1) Eleven instances of right bundle branch block of the broad S type, without any evidence of heart disease, are reported, and the relative benignity of this lesion, as compared with other types of bundle branch block, is being stressed.

(2) The average age at which the lesion was first discovered was 35 years.

(3) In the light of our present knowledge regarding the broad S pattern a diagnosis of coronary heart disease, regardless of the man's age, when based solely on the existence of this electrocardiographic pattern, is not fully justified.

HISTORY, DIAGNOSIS, AND TREATMENT OF COMMON ANORECTAL DISEASES

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A REVIEW of medical history shows that rectal diseases have been recognized from the earliest times, but that special study of these diseases has in general been neglected.

Montague[1] states, "Perhaps the earliest mention is to be found in the code of Hammurabi, written about 2200 B.C. In this we find instructions to the patient to the effect that he should "pay the doctor five shekels for curing him of a diseased bowel." Hemorrhoids are mentioned more particularly in the famous "Ebers Papyrus," which was written in Egypt about 1500 B.C. According to students of prehistory, the Hindus had a clinical knowledge of hemorrhoids and fistula as early as 1000 B.C. The immortal Hippocrates, who lived about 400 B.C., is said to have made frequent use of the rectal speculum. It is indeed interesting to view the instruments found in some of the Greek and other clinics existing before the time of Christ and to note how closely they compare in principle of construction to those in use today. In the museum of the Royal Society of Medicine in London there is a bronze speculum which was unearthed in the ruins of Pompeii. Equally interesting it is to note that the Bible was probably the first textbook on rectal diseases, since in the second book of Chronicles of the Old Testament we find a very good, though brief, clinical description of rectal prolapse: "And thou shalt have great sickness by disease of thy bowels, until the bowels fall out by reason of the sickness day by day." Elsewhere in the Bible, namely, in Deuteronomy and Samuel, occur words which were rendered into English as emerods by the old translators of the King James Version and generally looked upon as meaning hemorrhoids or piles.

Some of the glories of modern medicine appear anemic when we delve into history and find that Celsus in the first century A.D. classified fistulae into two classes: those which could be treated by ligature and others by knife. Both of these procedures are claimed as original devices on the part of modern surgeons. So, too, in the sixth century Aetius, physician to the court of Constantinople, advised the actual cautery for the treatment of procidentia. The modern mode of treating hemorrhoids is not greatly different from the method mentioned by Leonidas, who wrote in the second half of the seventh century, "Hemorrhoids can be removed by being cauterized after ligature."

With such an interesting historical background it seems all the more strange that proctology, the special study of rectal diseases, should not have been definitely formulated until 1835.

The American Proctologic Society was founded in 1899. The early growth of the society was stunted, perhaps by the undue conservatism which characterized its early members, since their plan seems to have been that of an accumulation of knowledge on the subject rather than its dissemination. It was not until 1916 that Dwight Murray, of Syracuse, accomplished the establishment of a section on proctology in the American Medical Association.

For a practical view of rectal diseases we will take up the more constant entities which are presented to the average doctor, because there are more rectal diseases being seen and treated by general practitioners than by all specialists in rectal diseases combined. There are no symptoms that produce more profound effects upon the nervous and

1 and 2. Montague, J. F.: *The Physician Throughout the Ages*, Vol. II, p. 537 and p. 539. Capehart-Brown Co., Inc., New York. 1928.

mental condition of a human than those produced by anorectal diseases, and there are no ailments more innocently contracted than anorectal diseases. These individuals present themselves to a doctor because of a few symptoms or complaints. Not many diseases have so few symptoms which are associated with such a degree of mental anxiety, severe pain, and at times general debilitation. These symptoms are constipation, prolapse of the hemorrhoidal tumors, pain of varying degree, bleeding, discharge, and itching.

The value of a good history, and the examination of the anus and rectum cannot be emphasized too strongly, and they are imperative if anorectal diseases are to be treated with satisfaction. It is not uncommon to learn from these patients that they have been treated for months or years by the directions found on some proprietary insertion, and that they have not been examined. Often "Individual[2] physicians dismiss a discussion of rectal disease with the statement that they 'get well anyhow.' Each of these viewpoints are no doubt expressions of honest opinion. Yet I believe they are all founded fallaciously." Proctoscopy and sigmoidoscopy are necessary and specifically indicated procedures, but it is a known fact that more than 95 per cent of the common anorectal diseases can be diagnosed by vision and an index finger. Let us now take up these diseases in the following order: constipation; hemorrhoids; fissure in ano; fistula in ano; cryptitis and papillitis; and pruritis ani.

Constipation

"Constipation[3] is a symptom of many forms of organic colonic and rectal dysfunction, but is far more common among persons who have no demonstrable organic lesion of the colon." Simple constipation or that unaccounted for by an organic lesion is caused by failure to heed the call to defecation. It is generally conceded that the desire to stool is caused by the filling of the rectal ampulla which sets off the nervous alarm when its walls are stretched. When this mechanism is repeatedly unheeded the nervous system, in turn, becomes accustomed to neglect and fails to give the alarm. A frequent history is that the constipated individual arises later than he should, eats a hurried and insufficient meal, runs for a conveyance to get to work on time, and the alarm for defecation goes off while in transit. By the time the individual arrives at his destination the desire to stool naturally is gone. When this performance is repeated daily, from school days to business life, there is very little a sensitive human nervous system can do, except fail to function. These individuals almost invariably turn to the use of cathartics, and I would estimate that there are more proprietary cathartics sold for torpid liver and biliousness than all other forms of medication.

This type of constipation, which is so common, should be called habit constipation and can be remedied only by the habit of regulation which is a long and tedious regimen of re-training a worn-out, neglected nervous system. These individuals should visit the toilet even at much inconvenience, and they should visit a toilet at regular daily intervals even if there is no call for defecation. Observation of most animals shows that the most natural time for bowel movement is shortly after a meal, and especially the first meal after arising.

Constipation caused by anorectal dysfunction can often be completely corrected by removing the pathological process and it is not unusual that these individuals are cooperative, and anxious to be relieved of a badly functioning anus and rectum. The usual pathology causing this type of constipation is located within the last inch of the intestinal canal and can either be viewed directly or inspected with the finger. They are hemorrhoids, fissure, fistula or cryptitis, and papillitis. These diseases cause constipation. Stool is avoided either because of pain, or because the sphincter muscles are so markedly hypertrophied from spasm, caused by irritation, that it is difficult to pass a stool. Alvarez[4] says "It is possible that a contracted anal ring might produce constipation by holding the feces back above the point where they can start the chain of reflexes that bring about defecation. The normal anal ring is perhaps two centimeters wide, whereas these diseased and spasmodically contracted ones appear sometimes to be all of three wide. When a bolus of food reaches a certain point on the back of the tongue, swallowing becomes inevitable; and similarly, when fecal matter reaches a certain point in the anal canal defecation should become easy."

Hemorrhoids

Hemorrhoids (commonly called piles) are those varicose tumors located in the anal canal, with a tendency to prolapse from the anus and to bleed. Hemorrhoids are often classified according to certain pathologic characteristics such as external, internal, externo-internal, thrombosed, edematous, ulcerated, strangulated, necrotic, or gangrenous. It is unnecessary to classify hemorrhoids other than external and internal, or externo-internal. External hemorrhoids are in the distal portion of the anal canal and can be seen. It is in these external portions where hemorrhage often occurs, very suddenly, resulting in thrombosis. This is called an external thrombotic pile; the symptoms are pain, throbbing in character. These may be single or multiple. The treatment is a small injection of local anesthetic, then excision of the top of the hemorrhoidal tumor, and extirpation of the thrombus; the edges of the incision are trimmed so that no new clots will form. It may be neces-

3. Alvarez, W. C.: *The Mechanics of the Digestive Tract.* Ed. 2. pp. 229-252. P. B. Hoeber, Inc., New York. 1928.

4. Alvarez, W. C.: *Introduction to Gastroenterology.* p. 339. P. B. Hoeber, Inc., New York. 1940.

sary to ligate an occasional arterial bleeder. An important landmark in anorectal surgery is the line where the skin of the anal canal and mucosa of the rectum join. This line is known as the pectinate line. Blood and nerve supply, venous return, and lymphatic drainage are quite different above and below the pectinate line. Above it the rectum, innervated by the sympathetic system, is relatively insensible to pain. Below the pectinate line the spinal nerves make the anal canal acutely sensitive to pain.

To simplify the understanding of hemorrhoids in general, let us divide the hemorrhoid into an external and internal portion by saying that the internal hemorrhoid is above the pectinate line and the external portion distal to it, even though at times the pectinate line may be prolapsed to an extent so as to make the entire hemorrhoid appear external in the anus.

There are two forms of treatment for hemorrhoids: the surgical treatment and the injection treatment. Both forms of treatment are recognized by outstanding proctologists throughout the world. Since it is my personal conviction that the injection treatment is unsatisfactory, often unnecessary, and misused, I will pass over this point by recognizing it as a means of treatment in the hands of some outstanding proctologists. I will also mention that only internal hemorrhoids are injected with sclerosing solutions, such as 5 per cent phenol in oil of sweet almonds, quinine, and urea hydrochloride or sodium morrhuate. These injections are done only on properly selected cases.

The surgical removal of hemorrhoids has not changed a great deal as we look back over the history. There have been many techniques developed with one ultimate aim, namely, that of removal of the disease and to return the patient to work in the shortest possible time. One of the most interesting developments in hemorrhoidal surgery was that of Walter Whitehead, a Manchester, England, surgeon who, in 1882, published the results of five years of doing the operation bearing his name. This operation has long been in disrepute, and justly so, in that most such operations finally produce an inversion of skin with a dry, sore anus, or an eversion of mucous membrane with a weeping anus and much irritation. A most excellent and comprehensive article on Whitehead's operation, by Chelsea Eaton,[5] Oakland, California, states in his conclusion: "Now, to answer the question as to what was wrong with Whitehead's work. The answer is that nothing was wrong with the work of Whitehead himself. The 'wrong' was done to the name of this great surgeon by the less skillful ones who were unwilling to take the blame for their own mistakes or mishaps. There is no more justice in dubbing a recurrent inguinal hernia after repair of a 'Bassini deformity,' than in calling the 'ectropin of rectal mucosa,' following an improper amputative hemorrhoidectomy, a 'Whitehead deformity.'"

My preceptor taught me, among other methods, to do a hemorrhoidectomy by the ligature method, using a number ten or twelve braided black silk ligature. This procedure was accomplished by properly placing a ligature through the upper pole of the internal hemorrhoid and letting the long ends of the ligature protrude from the anus. The hemorrhoid was then grasped by its external portion and dissected free from the external sphincter up past the pectinate line until the entire external and internal hemorrhoid was excised. Free bleeding at the time of dissection was expected and was common. This bleeding was controlled by a bulky pack of gauze for the sphincter to contract upon. The pack was left in place until the third day, at which time it was painfully removed, and the patient given from one to two ounces of castor oil to assure a clean-out. The ligatures usually dropped off in about one week, sometimes with a little persuasion. Hemorrhoidectomy was a severe ordeal, but surprisingly the patient healed with good results. Since those days I have performed hemorrhoidectomies by most of the methods in use, until I finally arrived at a method pretty much of my own, which is not greatly unlike my original teaching, but gives much less hemorrhage, definitely less postoperative pain, shorter operative time, shorter hospitalization, and excellent curative results. This hemorrhoidectomy is performed in the following manner: under anesthesia (preferably low spinal) the anal sphincters are gently dilated and the hemorrhoidal tumors presented and inspected. In place of the old, heavy silk ligature a chromic 00 catgut on a fine, round, curved needle is used. This ligature is placed through the upper pole of the internal hemorrhoid and each hemorrhoidal mass is excised in toto, being careful not to excise too massive an amount of tissue; then two to three locked sutures are placed through the hemorrhoidal bed to control active bleeders which were not ligated by the first transfixion ligature. These two or three sutures, and no more, are so placed that they will control the hemorrhoidal bed and keep the mucous membrane from spreading at its outward surface, and still not completely close the hemorrhoidal bed. The external hemorrhoidal dissection is never sutured. It is occasionally necessary to ligate an active bleeder using plain 00 catgut. The anus is then inspected and one strip of vaseline gauze is placed in the anal canal, to be removed in twenty-four hours. A soft diet is given the first postoperative day and hot sitz baths are begun at the end of the first postoperative day. Catharsis is not used. One-half ounce of mineral oil is given each night. The bowel usually moves on the third or fourth postoperative day and the patient leaves the hospital about one week from his entrance date. A hemorrhoidectomy by this method usually allows the patient to resume work

5. Eaton, Chelsea: *What Was Wrong With Whitehead's Work: An Appraisal of His Rectal Operation.* Am. J. Surg. pp. 83, 85. (Oct.) 1945.

within three weeks and is completely healed within thirty days from the operation.

Regardless of the type of hemorrhoidectomy performed, satisfactory results will not be obtained unless the operative field is given good postoperative care, which is a very simple matter. On about the fifth or sixth postoperative day the anus is inspected and the index finger, well lubricated, is passed into the anus. This is done twice weekly for the next two weeks and then once a week until completely healed. Mineral oil is discontinued as early as possible, for several reasons. Mineral oil makes a complete and satisfactory evacuation impossible, has a deleterious effect upon the fat soluble vitamins, prevents complete digestion, and interferes with bowel absorption. I continue to use small doses of mineral oil over a short period of time because I have failed to find any other satisfactory medication to replace it and still accomplish its purpose.

Fissure in Ano

Anal fissure is the most painful condition about the anus. Anal fissure is a longitudinal ulcer extending from the anal margin, where one will note the sentinal pile or overhanging skin tag. The upper pole of the fissure is at the pectinate line where a hypertropied papilla of Morgagni will be found. True anal fissure is a definite clinical entity and not just a crack or split of the anal margin. They are usually found in the posterior commissure of the anus, and sometimes in the anterior commissure. When multiple fissures or fissure-like lesions are noted about the anus, and especially when associated with condylomatous formations, one should be suspicious of syphilitic or gonorrheal disease. It is well to mention, at this point, that condylomata accuminata, or venereal warts, are no longer a surgical problem, but are best treated by the local application of 25 per cent podophyllin suspended in mineral oil. This causes the condylomata to slough and disappear without returning. Normal tissue is not injured. When this treatment is given the patient should be instructed to remove all medication by soap and water bath about three hours after the treatment is given.

True anal fissure very rarely responds to conservative treatment, and here again I am not in accord with the injection treatment sometimes used. By the injection treatment, I refer to the injection of anesthetic agents in oil, or quinine and urea hydrochloride. These agents are injected beneath the floor of the fissure and are said to give relief of pain. Even if pain should be relieved for a short time there is no curative value of injection.

There are several reasons advanced as to the cause of fissure, and with due respect to each of these reasons I prefer to accept the cause of anal fissure as pre-existing anal disease in the crypts of Morgagni. The most probable explanation for the location of fissure in the posterior commissure of the anus is that this is the point bearing the greatest trauma during fecal expulsion; however, a true fissure may occur in any quadrant of the anus. In the formation of a fissure let us consider the original pathology as being in the crypts of Morgagni located at the pectinate line. These crypts, when even slightly larger than normal, act as a shelf or a pocket, which scrape off and harbor fecal content and often foreign bodies contained in the feces. The crypt becomes a reservoir of stasis and ulcerates. A neighboring Morgagnian papilla seals over the crypt as a natural protective mechanism. This immediately becomes a small abscess which burrows its way to the anal margin and breaks out, forming a very short and superficial fistulous tract which soon sloughs or tears, leaving a longitudinal ulcer. There is considerable pain associated with this formation, and the expulsion of a bowel movement often causes the tearing of this tract so that the patient, and often the doctor, believes the occurrence has taken place in about the same manner as a split lip. This is definitely an erroneous conclusion. True fissure does not heal by treatment, and is usually aggravated by application of phenol, or silver nitrate, or the stick of lunar caustic. Fissure, being so extremely painful, causes the external sphincter to be in almost constant spasm, which in turn will soon develop a powerful and greatly hypertrophied external sphincter, from constant exercise. This acts as an obstruction at the anal orifice. Between excruciating pain and mechanical obstruction the bowel moves very infrequently. It is not unusual to hear from these patients that the bowel moves once each week, or perhaps once in two weeks.

Anal fissure is best corrected surgically, and with good postoperative results, in the following manner: under spinal anesthesia and after green soap and bichloride preparation, the anal sphincters are gently dilated. The anus, with its fissure, is inspected. Dissection of the fissure is begun by a crescentic shaped skin incision about the sentinel pile or skin tag. "The[6] incision is made through the skin of the anal margin at right angles to the external sphincteric fibers, at the juncture of the lateral and posterior quadrants of the anus, on either side. These incisions are then connected by the crescentic shaped skin incision which is made about three centimeters around the sentinel pile. The inner extremities of the incision on each side of the fissure are carried perpendicularly into the anal canal, just through the pectinate line so that another incision, connecting the inner limits, will be cut across the mucosa above the fissure with its hypertrophied papilla." The sentinal pile or skin tag is then grasped and, by means of sharp dis-

6. Ball, C. B.: *The Rectum, It's Diseases and Developmental Defects.* pp. 146-152. H. Frowde and Stoughton, London, England. 1908.

section, the entire area of skin and mucous membrane, outlined by the original incision, is now reflected off of the external sphincter muscle, and up under the entire fissure to above the pectinate line. After this dissection the fissure in toto with its hypertrophied papilla is exteriorized. A clamp may be placed across the mucous membrane above the papilla, and the entire fissure excised. I seldom use a clamp at this point. With this dissection the external sphincter is denuded in the area bounded by the incision, and marginal varicosities are excised. At this point it is well to note the degree of hypertrophy of the external sphincter muscle. In most instances it is markedly hypertrophied and it is advisable to cut through from one-third to one-half of its fibers, which can be seen to retract when they are cut. The cut edge of the mucous membrane is then sutured to the exposed surface of the fibers of the external sphincter muscle by means of 00 chromic catgut, at the anal margin. It should be particularly noted that mucosa is never sutured to skin. The anus is then packed with one strip of vaseline gauze, to be removed in twenty-four hours. The postoperative treatment is the same as for hemorrhoids, and the patient is not released until healing is complete.

Fistula in Ano

Fistula in ano is a discharging sinus or sinuses, with one or more openings in the anal canal, and an opening or openings either on the external surface of the body or in a neighboring viscus. The anus is usually the primary seat of disease, and from the original infection in one or more of the anal crypts of Morgagni the disease progresses through the various stages to formation of the fistula. Fistula in ano passes through the stages of anal abscess, then pararectal, or para-anal abscess, or ischiorectal abscess, then fistula. The early symptoms of fistulous disease are so constant that I believe the majority of fistulae could be avoided if the affected patients were presented to the proctologist early enough for proper treatment. This unfortunately is not the case. The patient is not presented until abscesses and fistulae are well established, and require complicated and often destructive surgery.

The earliest sign of fistulous disease is a sense of soreness, pain, or fullness within the anus. At this stage there is a crypt abscess, which can be opened within the anus, and most fistula formation avoided. Following this initial anal or rectal sign, which may last for a day or two, there will develop pain and soreness at the anal margin where the crypt abscess has burrowed down along the outside of the anus to the edge of the anal orifice. At this point there will be some degree of redness or induration and, with an examining finger in the anus, a small abscess can be palpated. The perianal fascia, being exceptionally tough, will often deflect the infectious process into the line of least resistance, which is the ischiorectal fossa, where enormous foul abscesses are formed, and by this time the patient is seriously ill. Chills, fever, and pain are the usual symptoms. The treatment is now protracted. The correction is often destructive, and the postoperative results are progressively less satisfactory as this destructive process is allowed to continue.

When should a rectal abscess be opened? is a frequent question. There is but one answer. A rectal abscess should be opened surgically the first time it is seen. If this rule were followed practically all abscesses and fistulae would be simple, easily cured, and with good postoperative results. It was formerly taught, and by many erroneously still carried out, that rectal abscesses should be allowed to become inflamed, localized, and suppurate before they are incised. This is a most unfortunate misdirection. This is one abscess which should never be allowed to progress farther than the first visit before incision and drainage, if the disease is to be kept simple and a correct cure is to be obtained.

In dealing with fistula and all other anorectal diseases, it is imperative that the operator be thoroughly familiar with the anatomy of the part to obtain satisfactory operative results. Especially, in fistula, it is important to keep in mind that the internal opening is to be found in an anal crypt, and that there is a general tendency to pass beyond the pectinate line in search for the internal opening, and to search high, even to perforating a new opening into the rectum, making a bad situation more grave. There are two main causes for failure to cure fistula; they are: mistreatment through erroneous ideas, until the disease has progressed beyond good repair; and misconception as to the point of origin of the disease.

It was formerly taught that tuberculosis was a frequent cause of fistula. Many of the failures to cure fistula were blamed on tuberculosis. This is by no means true, and it is a rare entity to demonstrate tuberculosis in this disease. It is true, however, that fistula and other anorectal diseases are frequently seen in persons with tuberculosis, but this may be attributed to general debilitation and not to tuberculous disease of the anus and rectum. At this time attention should also be called to the fact that fistula may be a complication of appendiceal abscess, tubo-ovarian abscess, or diverticulitis.

The cure of fistula, written by Celsus in the first century A.D., was classified as those cured by ligature, and those cured by cutting. The cure remains unchanged, but the understanding of anorectal anatomy and the pathology of fistula has been well worked out, thus allowing the surgeon to apply his art in a scientific manner.

Cryptitis and Papillitis

Cryptitis and papillitis is that disease of the pectinate line, within the anus, where the anal skin

and mucosa conjoin. There are semilunar folds formed between the lower end of the columns of Morgagni, which are called crypts of Morgagni. The inflammatory processes in these crypts or pockets are due to trauma from fecal material and foreign bodies, to chronic constipation, diarrhea, straining, and in part to the erect posture of man. The anal crypts and papillae become infected and ultimately the adjacent tissues are involved. I have repeatedly called attention to the pectinate line in the anus, and to the crypts and papillae of Morgagni, and I believe that it is generally conceded that 95 per cent of fistulae have their origin in this area.

The reason for infections at the pectinate line is the cupping of the crypts, which serve as a mechanical retention reservoir. The cure of cryptitis and papillitis is also mechanical by removal of the infected and hypertrophied parts. There have been numerous conservative treatments offered for the cure of diseases of the pectinate line, but the disease usually persists until the patient develops one of the already mentioned complications or until the disease is corrected surgically. It is always well to bear in mind that when this mechanical correction is made, each crypt and its associated papilla is completely excised. The excision of each individual crypt should not be limited to the small local excision, or there will remain a cupping defect at the pectinate line, which will continue to give the original symptoms. If, before surgical removal of the crypts, the operator will pass a fine silver probe into each crypt, it will be found that many crypts have a pocket extending to the anal margin. Therefore, it is wise in doing a cryptectomy and a papillectomy to carry the excision out of the anus through the skin. This procedure will facilitate drainage and eliminate the cupping at the pectinate line, both of which are the most desirable features in treating diseases of the pectinate line.

Pruritis Ani

Pruritis ani is that disease characterized by intractable itching within and about the anus. It is well known for its chronicity, its failure to respond to treatment, and its tendency to recurrence. There is no one specific cause for pruritis ani. The itching is caused by irritation in peripheral nerve endings in and about the anal canal, due to some local or systemic disease. Since there is no specific cause for pruritis and there is no specific treatment, pruritis is often one of the most baffling and rebellious diseases of the anus.

Pruritis ani is a disease, and not the transitory type of itching experienced by persons at occasions throughout life. We should recognize and distinguish between simple itching and pruritis ani. "This[7] simple itching may be due to lack of cleanliness, the presence of irritable discharges coming from the rectum and anus, character of toilet tissue, the irritation of certain types of underwear, dietary indiscretions, parasites, and so forth. Then the remedy may consist merely in adoption of such measures as will correct the irritating influence and keep the parts clean." The parasitic causes of itching are most often pin worms, which may be successfully treated by the administration of enteric-coated gentian violet, or the common itch which will respond to the sulphur treatment. The dietary causes of anal itching must not be forgotten nor their correction underestimated. One of the best illustrations of dietary indiscretions as a cause for skin irritation is to observe an infant being fed, or stuffed, with spinach, orange juice, eggs, and cereal. Even though these may be the simplest and most essential foods, it is not infrequent to see a reaction about the mouth and face as though it had been treated with some excoriating chemical. This same process may and does take place about the anus because of certain food constituents, or the end products of digestion and putrefaction, or even from the allergic manifestations of certain foods. If anal itching and irritation is called to the attention for treatment at an early stage it may be found to be due to one of the more simple causes and permanently corrected. If, however, the symptom or disease is allowed to progress unattended it will soon become that disease called pruritis ani.

Among the known causes of pruritis ani are trichophytosis, Monilia, pyogenic infections, high carbohydrate diet, allergy, fungi, and diabetes mellitus. Stokes,[8] in a very comprehensive discussion of the etiological factors involved, grouped them into five divisions: physiological, infective, allergic, psychogenic, and mechanical mechanisms.

Whatever the cause, if one may be found, a careful history and meticulous examination is imperative. An important part of the examination is inspection of the anus, the perianal skin, and hair, under magnification, the taking of anal swabs and the study of scrapings from the anal and perianal skin. Upon inspection of the anus it may usually be noted that the skin is moist, thickened, and excoriated, from scratching. The skin may be broken, infected, and pustules may be present. Sometimes the most aggravated types of itching are seen when the anal and perianal skin appear normal.

The cures offered for pruritis ani are as numerous as the theories of cause by various authors. The surgical treatment of this disease is problematic, but at times indicated in the removal of fissures, hemorrhoids, infected crypts and papillae, and infected skin tags. At times there are indications for severance of the sensory nerve filaments

7. Rankin, Bargen, Buie: *The Colon, Rectum and Anus.* pp. 609-623. W. B. Saunders Co., Phila. 1932.

8. Stokes, J. H.: *Pruritis Ani-Clinical Analysis.* New International Clinic. 1:147, 1940.

supplying the skin. The demoralizing effects of this disease are known only by one who has experienced it. These patients will submit to any form of treatment offered, often to their misfortune.

Treatments, such as tattooing the skin about the anus with mercury sulfide, or the injection of 95 per cent alcohol beneath the perianal skin, have been known occasionally to give satisfactory results but are not employed without danger of such sequelae as abscesses or scarification about the anal orifice.

Hill,[9] cites a series of cases, with the conclusion that "In the great majority of cases, pruritis ani is the result of a primary invasion by dermatophyton of the perianal tissue; it is toxic or dermatophytid reaction to a distant focus of this disease, or it may be an allergic manifestation of this, or some similar condition."

From my own observation epidermophytosis has been found to cause more cases of pruritis ani than any other one factor. I have also found that properly given x-ray therapy is the most satisfactory form of treatment, often giving complete cure. After the symptoms or disease is cured it is sometimes advisable to remove surgically the original site of infection such as skin tags, hemorrhoids, fissure or crypts, and papillae, where a nidus may remain and cause a recurrence.

9. Hill, M. R.: *Etiologic Relationship Between Dermatophytosis and Pruritis Ani.*, Trans. Am. Proct. Soc., 1940, p. 210. J. B. Lippincott, Phila.

Conclusion

In this brief resumé of common anorectal diseases only those diseases have been discussed which have been seen almost daily by every doctor since the beginning of history. These diseases have been recognized for over four thousand years, by means of vision and palpation, yet they are treated symptomatically and go undiagnosed over long periods of time. Most patients attribute all bleeding from the rectum to hemorrhoids, and will ask for or demand some local proprietary relief. Too often we find patients who have been treated for hemorrhoids without ever having had an examination.

It has been stated that about 95 per cent of these common anorectal diseases are located within the last one and one-half inches of the intestinal tract, and should almost never be overlooked in even the most cursory examination. It has been shown that these diseases are curable in a very satisfactory manner. Patients cured of anorectal diseases are often the most grateful and appreciative of all surgical patients.

If this resumé serves only as a reminder that anorectal examination is a definite and important part of every examination, these diseases frequently will be diagnosed in their early stages, at which time they may be cured without difficulty or complications.

PREVENTION OF DISEASE UP TO PUBLIC AS WELL AS PHYSICIAN

"At the present time approximately 4,000,000 Americans are suffering from heart disease, and another 5,800,000 from hardening of the arteries and high blood pressure," Edward L. Bortz, M.D., Philadelphia, president of the American Medical Association, pointed out in a paper before the 12th Annual Meeting of the Mississippi Valley Medical Society, Burlington, Iowa, October 2, 1947.

"In our population of 140,000,000 people, one out of every 20 is a victim of some form of heart or blood vessel disorder. This is a rather appalling condition when one considers that the battle casualties in World War II, which took the lives of 325,000 of our finest boys and girls, were occurring at the time that 2,000,000 men, women and children at home were destroyed by lesions of the heart and vascular system. There are three times as many deaths due to diseases of the cardiovascular system as occur from cancer, and six times as many as are caused by accidents, 10 times as many as occur from tuberculosis."

"It is rather remarkable to consider that in 1945 the American public contributed $16,000,000 for research and care of patients with infantile paralysis, which represented $13,490 per death. On the other hand, $39,000 was contributed for the same kind of service including research and other beneficent activities directed to amelioration of symptoms of cardiovascular disorders, which represented .07 or 7 cents per death for the most common of all destructive processes of human life."

"Nor are disorders of the heart and blood vessels the only diseases which take an unnecessary toll of American lives. In 1945 the leading causes of death in the United States were:

Diseases of heart and blood vessels	587,000
Cancer	177,000
Accidents	96,000
Nephritis	88,000
Pneumonia	68,000
Tuberculosis	53,000."

"It is only in those communities where the public has elected to avail itself of the benefits which modern science has to offer that the life span has been increased. For example, among the white population of certain states like South Dakota, Massachusetts, and New Hampshire, the average life span is close to 68 years. However, among the Negro population in the southland where illiteracy is high and modern health safeguards are not yet utilized, the life span averages approximately 50 years, and has not changed appreciably in the last quarter century.

"It is high time for the public, and the loquacious minority which is screaming for the physician to do something about the medical situation, to realize that a program of health education, accident prevention, prophylaxis against various diseases, a modern nutritional program for all schools, and periodic health inventories for all citizens will have a tremendous bearing on the development of healthier national population. . . . Social experiments can readily be set up in local districts where the major problem is an economic one. On a five-year trial pilot study observations gained should serve as the basis for improvement in the system of medical service that would be acceptable, indeed pleasing, to all portions of the community."

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THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

UNIVERSAL SOCIALIZED MEDICINE

THIS caption may sound a bit odd, but nevertheless, if certain individuals right here in our own country had their way, that is just what would happen.

Several weeks ago we received from Washington a little weekly letter, privately written and privately circulated, stating that within a short time there would be "discovered" a definite program looking forward to the socialization of medicine in Japan, as a starter.

Now comes the information that a government committee investigating such publicity and propaganda, this committee headed by Representative Forest Harness, of Indiana, has uncovered much of the plans and proposes, if possible, to do something about it.

Congressman Harness, as an opening wedge, proposes that all appropriations for overseas travel by staff members of the Social Security Board be summarily cut off. It seems that along in the latter part of August a "health mission to Tokyo was undertaken, the expense thereof naturally coming from United States funds."

Mr. Harness, after due investigation, made some findings, all of which are of much interest to us. First, he found that every member of this "commission" is an advocate of socialized medicine in the United States, as well as throughout the world. Then he discovered that the real purpose of this group was to lay the foundation for the socialization of medicine, in Japan, that the whole scheme originated right here in Washington, in the Division of Research and Statistics of the Social Security Board. That, while General MacArthur, in supreme command in Japan, *does not* favor any form of socialized medicine, yet the plot to send over a special committee for this purpose originated right in his headquarters, by a group sent from Washington for this special purpose. Further, it has been learned that the Surgeon General of the Army was not consulted about the plan.

It also is learned that one of the members of the "commission" is Dr. B. M. Davis, a son of Mr. Michael Davis, present chairman of the committee for public health!

Now this man, "Mike" Davis, is no stranger to us; for many years he has been a leading proponent of socialized medicine; not a doctor, just a

chap who managed to get in "right" with the old New Deal outfit. He is but one of a host of others connected with the health program of our country, practically all of whom are in favor of the regimentation of the grandest of the professions.

Time was, and not so long ago, that too many physicians became complacent about this thing; they said, "Well, the Wagner-Murray-Dingell Bill did not get out of committee, so why should we worry about such things."

But here we face a new attack, a plan to hop over to Japan and put into operation the very thing we have so long opposed and, too, *all this at the expense of our local taxpayers.* It is our opinion that it would cost millions of dollars to put this plan into operation in Japan, plus the maintenance costs, which would be terrific.

Apparently there still are "strange doings" going on in Washington, even after we had thought things were looking up. It becomes our duty to keep on the alert and, in this instance, to do everything possible to stop this expenditure. If this "committee" is cut off from the Federal Treasury for such fool notions their program will stop, right now. Of course, there is every likelihood that if they are thwarted in this program they soon will bob up with something new!

"THE PEOPLE WANT HOSPITALS!"

SUCH was the remark recently made to us by a down-state county official—a layman. He was speaking concerning a move to at least double the capacity of the county hospital in his home county. We well recall that when the original hospital project was first broached there was no little objection raised, primarily because of the tax increase such a project would involve.

But now, it seems, there is a different feeling about it; they not only approve of the present hospital, they want its capacity doubled, right now, in the face of the fact that building costs are at a maximum level.

Asked to explain the situation, our informant remarked that people have become "hospital conscious"; they have learned that right at home they can get the best medical and surgical care. He went on to say that many of the residents of his county have come to believe that it is no longer necessary to go to distant cities, there to consult "big name" physicians and clinics, that this same service is available in their own hospital—if there was room enough for all.

Following the recent war several physicians of that county have taken postgraduate study and in conversation with one of them he remarked that it was no longer a problem of handling cases, the problem was to have adequate hospital facilities.

Our observation is that this is not an exceptional interest; for some time we have noted in the Indiana press comment on the building of this and that county hospital, preliminary plans for such a building or the formation of special committees to study the local situation.

Nor is this confined to rural areas; in most of our larger cities there is an ever-increasing demand for more hospital space. In four decades or more we have observed this thing, starting from the time when there was a rather universal dread of being sent to a hospital; now the story is different; when one becomes acutely ill or has had a severe injury the first thing he asks for is that he be taken to the hospital.

Our judgment is that within the next twenty years the hospital situation in practically every part of the country will be an entirely new picture. Save in sparsely settled areas hospital facilities will be almost immediately available to all.

And when that day finally comes we also will find the medical and surgical services improved in like degree. Some of our larger clinics will, of course, continue, but for the most part medical and surgical services will be available practically at one's door.

DR. JOHN STOUGH BOBBS

THE following article appeared in the *Indianapolis Times,* written by Anton Scherrer, one of the best Hoosier feature writers. It clears up so many misunderstandings regarding Dr. Bobbs that we felt our readers would like to have it.

"Dr. Bobbs and the 40 Gall Stones

"Dr. John Stough Bobbs of Indianapolis was the first—anywhere in the world—to perform the operation now known as cholecystotomy, a slick example of medical sesquipedalianism which, when unwrapped, turns out to mean the removal of gall stones.

"Mary Wiggins was the beneficiary of Dr. Bobbs' skill. She had to climb the two steep flights of stairs to get to the top of Vinton & Kiefer's drugstore at the southwest corner of Meridian st. and the alley now known as Pearl (where the Ayres' people now do business). And it was there—on June 15, 1867—in a bare, barnlike room made to serve the purpose of an improvised hospital, that Mary was relieved of more than 40 gall stones.

"The exact number of gall stones is veiled in obscurity. The dereliction on the part of history seems strange when viewed in the light of the fact that Dr. Bobbs had a gallery of kibitzers watching him that day. At any rate, it is fairly well established that among those present at the party were Drs. D. H. Oliver, R. N. Todd, F. S. Newcomer, George W. Mears, John Cameron, John P. Avery and John Cominger. With so many doctors looking on, you'd suspect, of course, that somebody would have kept the case history straight. It appears, however, that they lost count after the 40th gall stone was removed.

"Got Married After Operation

"After the operation, Mary Wiggins was put to bed in charge of an anonymous English nurse whom Dr. Bobbs had picked up somewhere. Six weeks later Miss Wiggins jumped out of bed none the worse for her experience. As a matter of fact, she got married almost immediately — Burnsworth was the chap's name. They lived happily ever afterward, which is to say for a period of 46 years after the operation. She died at the age of 77. Dr. Bobbs, who didn't have the luck to have gall stones, died in 1870—three years after the operation.

"One year after performing the memorable operation, Dr. Bobbs let the world in on his secret by way of a paper labeled "Lithotomy of the Gall Bladder." It was read at the annual meeting of the Indiana Medical society. Subsequently, it was published and read the world over. It had all the doctors wondering why they hadn't figured out the thing for themselves.

"Well, that's the point of today's piece. It's because Dr. Bobbs was one of the most remarkable men ever to come to Indianapolis. He arrived in 1835 by way of Cumberland county, Pennsylvania, his birthplace. He was 26 years old at the time and had practiced medicine before coming here, but without benefit of a doctor's degree. During his first year of Indianapolis citizenship, however, he took advantage of a winter's dissections at the Jefferson Medical college. His work impressed the faculty to such a degree that they handed him a doctor's degree forthwith for fear the pupil might show up the professors.

"Made Dean of Medical School

"After that, he had the sick world beating a path to his office which, by the way, was in a house located on the site of the present State Life building. The trustees of Indiana Asbury university (now DePauw) tendered him the chair of surgery in the Central Medical college which was being established in Indianapolis at the time. He accepted and was made dean, to boot. He served as a member of the board of health from 1854 to 1857 and followed it up with two terms as state senator. When he was 52 years old, he served with distinction in the first campaign of the civil war.

"My only reason for combing the subject so thoroughly today is because of a determination to clear up the lacoric inscription on the memorial tablet in the reading room of our Central Library. It says: "John Stough Bobbs . . . Illustrious Surgeon . . . Patriotic Citizen . . . Self Sacrificing Benefactor . . . Servant of God Through Service to Mankind."

"Pretty enough, but it leaves a lot to the imagination. Indeed, the inscription goes a long way to disprove Emerson's contention that the British have the greatest command of under-statement of anybody in the world."

Editorial Notes

A new hospital project down in Tell City, Perry County, seems well under way. This is one of the few spots in Indiana where hospital facilities are not at all what they should be and we are pleased to note, according to press reports, that favorable action seems well under way.

A down-state paper, in discussing the old question of socialized medicine, concludes, "What the medical profession has opposed is socialization or regimentation that would make the doctor a tool of politicians. And all evidence indicates that the American people are overwhelmingly opposed to that."

Commenting on one of our recent editorial notes, the *Indianapolis News* suggests that with the opening of our schools is a good time for the inoculation of school children against the preventable diseases.

In the death of Robert N. Nye our state medical journals lose one of their stanchest friends. Dr. Nye, a brilliant writer, was for the past ten years Managing Editor of the *New England Journal of Medicine*. He has made a signal success of his work with the magazine and was looked upon as a medical editor of unusual attainments. His magazine came to us every two weeks and, in addition to the scientific articles, most of which were of an unusually high order, we read his brief editorial comment with much pleasure and much profit.

Well, we read that some 1,200 Hoosier farm folk are back from their little vacation trip through the West and on up into Canada. They had three special trains, all Pullmans, plus a generous complement of dining cars. They hit the West Coast and traveled from San Diego to Vancouver, all reporting a grand time, according to Maurice Early of the *Indianapolis Star,* who accompanied them.

Only a few years ago such a "vacation" would have been vetoed by the average farmer—"just can't afford it," he would say. We recall our Wild Cat days when time off meant attendance upon the Cutler picnic, with perhaps another day to go to Delphi for the Burlingtom Old Settlers Picnic, and that was just about the end of vacation talk.

Of course, if Barnum's Circus happened to be coming to Logansport or Frankfort, a sizeable group of farm folk would manage to attend, but a long trip, by rail, was simply out of the question. We are glad to read of these little "jaunts" our farm folk are taking; does 'em a lot of good, besides permitting of a first-hand view of how other farm areas carry on.

Naturally, the doctors are blamed! This time it is because of the "confusion" arising over the provisions of the marriage license law. It seems the profession is charged, in many instances, with being dilatory, not to say careless, in making out the "blood test" reports, the delay often resulting in the postponement of nuptial ceremonies.

The law has been in effect since March, 1940, and complaints have been coming in since that time. Forty-two private laboratories have received the official "nod" to go ahead with these blood examinations, while of course the state laboratories are available for such work. In some instances the physician is charged with neglecting to state that the blood sample is for a pre-marital test, in which instance the laboratory makes the routine examination and is in no special hurry to send out its findings.

Then, too, there is the violation of the provision that all blood samples must be sent via mail, the findings likewise. Looks as though the legislature will have to do something about many of these details.

Three Peru physicians, Drs. John E. Yarling, D. C. Ridenour, and F. M. Lynn, recently were honored by the local society for having concluded fifty years in the practice of medicine. Dr. Edgar F. Kiser, Indianapolis, was the guest speaker for the evening.

Dr. Kiser, probably the foremost student of the history of medicine in Indiana, went 'way back to the jungle days to show the progress made in the healing arts.

Fifty years is a long time to have served humanity in any capacity and to have accomplished this in the profession of medicine means a lot of hard work and a lot of hardships over a long period of years. Each man who reaches this goal is more than entitled to the encomiums of his confreres.

As was to be expected, suit has been brought in a down-state court to compel hospital authorities to admit a local physician to the staff. In his complaint he admits that he cannot comply with all the rules set forth recently by the American College of Surgery, but does insist that he is duly licensed to practice his profession here in Indiana. We shall be interested in learning just what the court authorities think about it.

There still seems to be some controversy about the site of the Veteran's Administration Hospital, in Indianapolis, most being in favor of a site adjoining the Medical Center, a few urging its location on Cold Springs Road. It seems to us that the former site, without any question, is the preferred one. It is very convenient to the medical school, a large number of whose faculty will be on the staff of the new hospital. We recently saw a statement of the number of hours these men put in at Cold Springs, in addition to their teaching chores. It would seem to be most convenient to have them combine this work, without traveling a long distance between the two posts. Then, of course, there is the added advantage of having another hospital on the campus.

Robert E. Neff, superintendent of the Methodist Hospital, Indianapolis, is quoted as having said in a paper read at the recent meeting of the American Hospital Association, in St. Louis, that there seems to be a "headlong movement toward specialization by the younger medical graduates" and that too little attention is being given to the general practitioner. He also remarks that the general practitioners are showing more resentment against some of the rules now in the process of attempted enforcement. All of which is true; the G. P., long the backbone of the medical profession and still, in our opinion, the smartest, best trained group of them all, is not going to be supine about this thing; they are going to "demand their rights," and they will get them, too.

We recall seeing, many years ago, a pinhead with the Lord's Prayer engraved thereon. Being somewhat familiar with the Prayer we did not attempt to read this particular version, though we were assured that every word was there. The other day there came to headquarters office a post card, from some place "Down East," that was definitely a rival of this pinhead. We never saw so many letters penned into such a small space as this. No, we did not take time to read it—made out a little of what it tried to tell us, then set it aside until some day when we had our magnifying glass at hand. It is odd how many such things come into the office of a magazine like ours. A newspaper, for example, expects such things, they are a part of the daily life, but a professional publication hardly expects such things.

Rollis Weesner, for the past few years serving as Executive Secretary of the Lake County Medical Society, has resigned to accept a similar post with the Indiana Cancer Society. Mr. Weesner had succeeded Rollen Waterson, the first full-time secretary of the Lake County group. He has had extensive experience in various civic organizations in Lake County, serving as attendance officer for a number of years and really making a job of this, which formerly had been considered a soft-snap political job. He was very active in the Community Chest programs, the cancer drives, the American Red Cross, the County Tuberculosis group, along with a host of other similar activities. We predict that Rollis will do "big things" in his new job.

We talk about pre-school examinations for our youngsters, most of the profession having come to believe this program has a lot of merit. We should not overlook the fact that along in February we have another group ready for school, for both the first grade and kindergarten. This new group should have the same attention as those checked during the past summer season, seeing to it that they have been vaccinated and have had the protective inoculations at the same time. This program, in recent years, has done wonders and in certain counties where it has been carried out 100 per cent the payoff has been found to be enormous.

The Nurse Scholarship program of the Indiana State Medical Association is meeting with general approval over the state, judging from the number of newspaper clippings we have received about the program. It is unfortunate that the funds for the program are so limited and it is hoped that, one of these days, some philanthropic individual may become interested and furnish the association with sufficient capital to enlarge the project greatly.

President's Page

DUST IN YOUR EYES VERSUS *RINCEZ-VOUS LES YEUX*

THIRTY years ago, while on quite an extended vacation for your Uncle Sam with the AEF in France, I learned the expression, *Rincez-vous les yeux.* Freely translated it means: wash out your eyes; or, rinse the dust out of your eyes so that you may see more clearly.

I never quite forgot the maxim, and it frequently has recurred to me over the years as a stimulating psychic impulse under many different circumstances and situations where dust is being kicked up or tossed about to the extent that visibility is reduced to zero-zero. It just does seem that rinsing the eyes enables one to see more clearly the thoughts and pressures and counterpressures, and wheels within wheels, and the sometimes invisible hands responsible for certain apparently otherwise unexplainable activities and reactions.

Witness this as of now, in these worrisome days in our own country, at local, state, and national levels in the fields of pressure politics regarding our socio-economic problems, and also in the intense and foreboding drama now in progress in the realm of international power-politics where we are seeing a historical re-enactment of the old, old saga of dog eat dog. *Rincez-vous les yeux.* It might help.

PHYSICIANS OF INDIANA

let's apply the motto to ourselves, as regards organized medicine. I frequently have made the remark that the great Indiana State Medical Association is bigger than any one man; I.S.M.A. work and activities go on and on, regardless. This is true. I know it to be true. You know it to be true. Yet, paradoxical as it may seem, your great association also needs every man, every physician, in its fold; not only just as a dues-payer, a member going along merely for the ride, a reaper who soweth not; no, your great association needs your activity, your executive brain power, your organizational ability, and, above all, your co-operative spirit. *Rincez-vous les yeux,* and you'll find a way.

Every one of you knows a member or members who hardly ever attend county society meetings and who have not met their associates and friends at the state level for years and years. Why? *Rincez-vous les yeux!*

Yes, I know most of the excuses, having heard them all many, many times. They are old, old stories. It is hard, indeed, to think up a new one! "Oh, I used to go, but I've lost interest." "I'm busy." "I haven't the time." "So-and-so runs it, why bother?" And so on, *ad infinitum!* You are throwing dust into your own eyes! *Rincez-vous les yeux!* Then you will find that you have given hostage for a life-time of sacrifice and service to

ORGANIZED MEDICINE

which made you what you are today, regardless of what you think, regardless of your prima donna complex. Otherwise, you are woolgathering, moonraking, dreaming pipe dreams. Organized medicine gave you your medical education. Organized medicine wrote the books. Organized medicine furnished the facilities, internships, residencies, hospitals, hospital staffs, instruction courses, clinics, publications, all. Men of organized medicine led your first faltering professional footsteps. Where would you be today without the benefits bestowed upon you over the many years, even for generations, by organized medicine? Oh, yes, you THINK that you're a self-made man, that you pulled yourself up by your own boot straps, that you owe nothing to no one, nowhere! That's dust in your eyes! Suppose, just for a small incident, that, *even after you had received your M.D. and your license to practice,* suppose that from that time on you never again had access to any of the activities or facilities or products or results of organized medicine's efforts. Where would you now be? As the result only of your own boot strap lifting? *Rincez-vous les yeux.*

Self-made, when claimed by a physician, all too frequently is a complimentary term for an uncomplimentary result; he either quit on the job too soon, or he better had let out the contract. Medical practice is more than a mere profession; it is more than a philosophy; it is more than a religion. It is a CRUSADE. For the public weal! He whose medical psyche runs only toward the material getting of more and more for less and less, toward peaceful evenings end on end without call, toward undisturbed week-ends off, and toward double-feature vacations without limit—well, he just has missed the boat! Universal trend? Perhaps. Probable box score—no hits, no runs, no errors!

Our pioneer forefather physicians knew naught of such doctrines, and hence they needed no hired men as purveyors of public opinion. No, they created their own good public relations. *Rincez-vous les yeux.*

Sincerely,

Floyd D. Romberger

MATERNAL, NEWBORN, AND PREMATURE INFANT CARE, AND CESAREAN SECTIONS IN INDIANA HOSPITALS*

ROBERT E. JEWETT, M.D.
GERALD W. GUSTAFSON, M.D.

INDIANAPOLIS

IN this article we intend to present and discuss certain interesting differences in hospital care of mothers and infants in Indiana. The information and data used were submitted in the best spirit of co-operation by the hospitals in the state, and they cover a period of time including the years 1943, 1944, and 1945, years of peak load in hospital maternity care during World War II. Certain facts were obtained from the birth statistics of the United States Bureau of Census for the years 1943 and 1944.

The reported facts, when analyzed, show great differences in the percentage of live births occurring in hospitals in the different areas of the state. They also show differences in the percentages of births by Cesarean Section in the various hospitals, and variations in maternal and neonatal mortality rates and death from prematurity.

In reviewing the data, the hospitals were separated into groups according to the numbers of live births occurring annually. This grouping was arrived at by diligent effort and experimentation in previous mortality studies.[1] Group I includes hospitals with 1 to 199 births per year; Group II, 200 to 499 births per year; Group III, hospitals with 500 to 1,500 births per year; and Group IV, hospitals with more than 1,500 reported births per year.

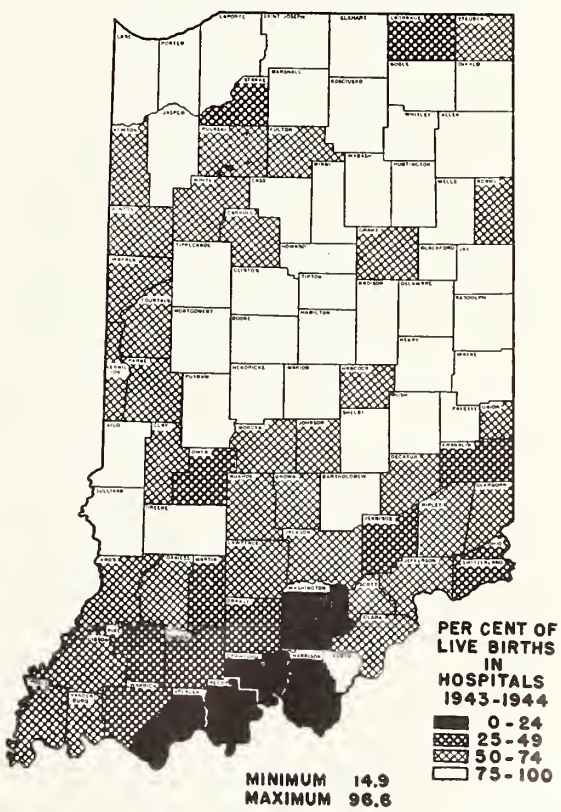
In order to analyze the problems in premature care, we have arbitrarily divided the state into regions which represent certain problems relative to the availability of existing hospital facilities, distances from trade centers and existing travel routes. This was done with a view to delineating logical regions for the establishment of premature care centers, thereby reducing neonatal mortality by making better premature care available to each region in the state.

Map Number I illustrates a percentage of births in hospitals by counties, and Map Number II shows the arbitrary regions relative to the needs for hospital facilities and premature centers.

PERCENTAGE OF LIVE BIRTHS IN HOSPITALS BY COUNTIES

During the years covered by the study the facts show that the percentage of births occurring in hospitals in the various counties in Indiana varied from 14.9 per cent in Washington County, as a minimum, to a maximum of 96.6 per cent in St. Joseph County. Analysis indicates that maternal and newborn deaths occur more frequently in counties with a low percentage of births in hospitals than in counties with either a very high percentage of births in hospitals or with hospitals with optimum hospital facilities. Certainly newborn deaths from prematurity were more fre-

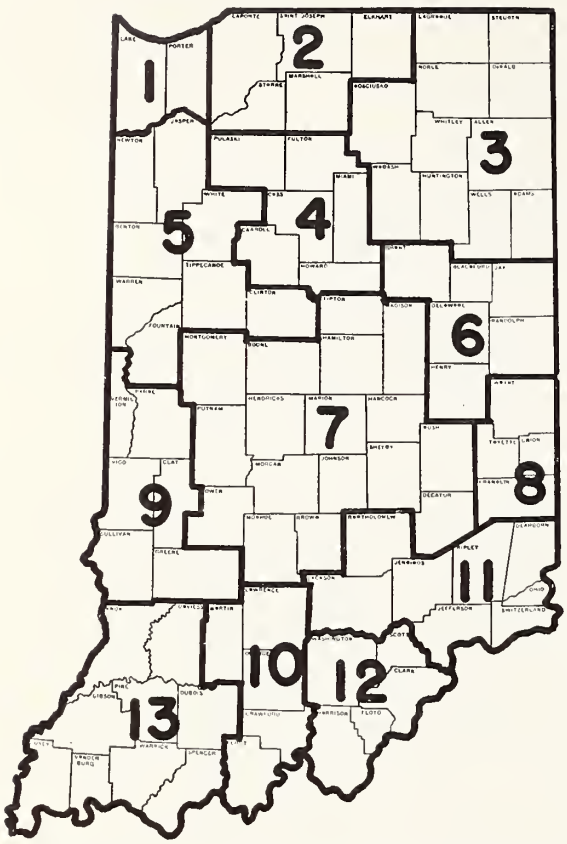
MAP 1. LIVE BIRTHS IN HOSPITALS—1943-44



* This study was made for the Committee on Maternal and Child Health of the State Medical Association, G. W. Gustafson, Chairman. Credit and appreciation is due the Committee members for advice and counsel, the Indiana Hospital Association for its co-operation, the State Board of Health for the use of its facilities; and particular acclaim must be given to Miss Mary Ellen Warstler, R.N., for her diligent efforts in collecting and compiling the data.

[1] Jewett, R. E.: Report of Maternity Homes and Hospitals. *J. Ind. State Med. Assn.*, July, 1942.

MAP 2. PROPOSED PREMATURE CARE CENTER REGIONS



quent in counties or areas where the percentage of live births in hospitals is low, or where hospital facilities are not adequate.

Cesarean Section Rates by Counties and Hospital Groups

The data shows that there is a wide variation in the percentage of births by Cesarean Section by counties and in the hospitals of different sizes. The percentage of births by Cesarean Section seems to occur more frequently in counties with hospitals of the small general hospital character. Analysis, by counties, also shows that there tends to be a somewhat higher neonatal mortality within counties with hospitals of the first type, although this is not reflected in maternity mortality, since the number of occurrences are too few during the period of time covered to rule out the effects of chance alone.

Disregarding counties, and analyzing the Cesarean Section rates in the hospitals according to the number of live births occurring annually (Tables Number I and II), we find certain interesting variations. It will be noted that the Cesarean Section rate in hospitals having less than 200 deliveries per year is the lowest, whereas the rate is highest in the hospitals with 200 to 499 live births per year.

Group I, for the most part, includes small nursing homes or small office hospitals with few beds operated by a practicing physician. In most of these institutions it is the practice to take complicated cases to a larger center or to practice very conservative obstetrics. It will be noted, however, that the Cesarean Section rate is very low in the institutions having more than 1,500 live births per year, and that the maternal death rate is lower in both Groups I and IV. The highest Cesarean Section rate occurs in Group II, which includes the average small general county hospital of from 30 to 70 beds.

The basic material for this study also showed that the Cesarean Section rate is extremely high in certain specific hospitals, amounting to 11.7 per cent in one institution. This would seem to indicate a tendency of the physicians in this locality to resort to more radical measures rather than conservative obstetric procedures. This tendency seems to be constant in these specific areas, and it indicates that there should be an analysis of this practice by the medical staffs concerned. We believe that it indicates a tendency on the part of the physicians locally to place a greater confidence in their surgical ability than in their obstetric ability.

A high Cesarean rate is not generally considered to be good obstetric practice, since it is generally

TABLE I
MATERNAL DEATHS AND CESAREAN SECTIONS IN INDIANA HOSPITALS
1943-1945

Groups	Deliveries Per Year	Total Live Births	Number							
			Total Cesarean Sections	Total Maternal Deaths	Maternal Deaths from Selected Causes					
					Hemorrhage	Infection	Toxemia	Embolus	Other	Unknown
I	1-199	9,659	221	9	1	—	3	2	1	2
II	200-499	49,354	1,751	60	10	2	12	10	10	16
III	500-1499	79,720	2,523	95	16	4	25	10	23	17
IV	1500 and over	30-213	721	27	6	1	4	4	5	7
Total		168,946	5,216	191	33	7	44	26	39	42

TABLE II

MATERNAL DEATHS AND CESAREAN SECTIONS IN INDIANA HOSPITALS
1943-1945

Groups	Deliveries Per Year	Total Live Births	Per 1,000 Live Births							
			Total Cesarean Sections	Total Maternal Deaths	Maternal Deaths from Selected Causes					
					Hemorrhage	Infection	Toxemia	Embolus	Other	Unknown
I	1-199	9,659	22.9	0.9	0.1	—	0.3	0.2	0.1	0.2
II	200-499	49,354	35.5	1.2	0.2	0.04	0.2	0.2	0.2	0.3
III	500-1499	79,720	31.6	1.2	0.2	0.05	0.3	0.1	0.3	0.2
IV	1500 and over	30,213	23.9	0.9	0.2	0.03	0.1	0.1	0.2	0.2
	Total all hospitals	168,946	30.9	1.1	0.2	0.04	0.3	0.2	0.2	0.2

reported that both the maternal and neonatal mortality are greater in Cesarean Section births than in births by the vaginal route. This conclusion was reached in one of our own hospitals after a ten year study by Bowdoin.[2] Irving,[3] after analyzing 1887 consecutive Cesareans, concludes that "Normal delivery was 15 times safer than Cesarean Section for the mother and over 2½ times safer for the infant." Although we know that the indications for section have much to do with the prognosis, these facts still argue strongly for conservative obstetrics.

We feel that these facts constitute a challenge to all of the hospitals in Groups II and III to analyze their procedures and obstetric practices.

Maternal Mortality and Its Causes

Maternal mortality throughout the nation has decreased to such an extent, a trend for which we can be proud and grateful, that the number of occurrences do not lend themselves to very reliable conclusions. However, Tables I and II do disclose certain facts of interest and limited data of a comparable nature. It will be noted that the maternal death rates are lower in Groups I and IV. In the first group this is probably true because serious complications are referred to hospitals with better facilities, and in the latter because of the more complete facilities and the availability of specialists and consultant services.

The facts pertaining to the causes of maternal deaths definitely indicate the retirement of death from infection from a high to a relatively low position among the causes of death. During the last two decades great improvement in asepsis and the current use of chemotherapy brought about this change. Toxemia still holds a place above hemorrhage, but it should be remembered that these deliveries all occurred in hospitals where blood replacement is usually available. If this study included home deliveries, and certain diagnoses, hemorrhage might loom much more prominently.

The number of deaths from embolus should be noted, since it is only in the last few years that this diagnosis of the cause of death has been frequently reported. A final observation should be made in regard to "other and unknown causes of death," since these diagnoses occur more frequently in the Groups II and III than in Group IV. The facts reported in Group I must be ignored, but staff policies requiring more careful diagnosis and reporting should be instituted in Groups II and III.

Neonatal Mortality

The facts regarding neonatal deaths in hospitals (Table III) do not lend themselves to any striking conclusions. It will be noted that the death rate is lowest in Group IV and higher in Groups II and III. We would expect a moderately high death rate in Group I, since institutions included in this group seldom have facilities for emergency care of the newborn infant, but this might indicate some advantages in conservative management during delivery. The higher rate of neonatal deaths in Group III challenges our analy-

TABLE III

BIRTHS AND NEONATAL DEATHS IN HOSPITALS, INDIANA, 1943-1945

Group	Average Number of Deliveries per year	Total Live Births	Neonatal Deaths	
			Number	Rate
I	1-199	9,659	172	17.8
II	200-499	49,354	814	16.5
III	500-1499	79,720	1527	19.1
IV	1500 and over	30,213	460	15.2
	All Hospitals	168,946	2973	17.6

[2] Bowdoin, G. E.: Review of Ten Years of Caesarean Sections at Elkhart General Hospital. *J. Ind. St. Med. Assn.*, August, 1947.

[3] Irving, F. C.: Ten Years of Caesarean Section at Boston Lying-In Hospital. *Am. J. Ob. & Gyn.*, December, 1945.

tical abilities. It should be pointed out that in Group III there are included a number of large hospitals with pediatric ward facilities. Group II represents the average small general county hospital where pediatric wards are not usually maintained, and admission of complicated pediatric cases from the outside is not common practice. If pediatric ward services are available, as in Group III, there are more admissions of complicated cases from the outside and deaths are assigned to the hospital. These statements must not be taken as conclusive, but they could mean that the pediatric ward services in hospitals in Group III merit some efforts towards improvement, since the neonatal death rate is so much lower in the hospitals in Group IV.

Premature Births and Deaths in Hospitals

Prematurity is the greatest single cause of death during the neonatal period and the first years of life, and the total number of deaths so caused almost equals the deaths from all other causes. It would seem that if we are to reduce neonatal and infant death rates, and we might include the death rates at any age, we must reduce death from prematurity and improve our facilities for premature care. The death rates from prematurity, according to the hospital groups (Table IV), represent the proportionate frequency we would expect, being more numerous in the very small hospital without proper facilities, and least numerous in the very large hospital with optimum or near optimum facilities.

TABLE IV
PREMATURE BIRTHS AND DEATHS* IN HOSPITALS, INDIANA, 1943-1945

Group	Average Number of Births	Number of Premature Births	Number of Premature Deaths	Death per 1000 Premature Births
I	1-199	237	76	321
II	200-499	1407	389	276
III	500-1499	3354	716	213
IV	1500 and over	1298	239	184
	All Hospitals	6298	1420	225

*Premature Births constituted 3.7% of all live births.

Other known factors enter into this problem of premature mortality. It is well known that neonatal deaths from prematurity are more apt to occur in home deliveries, and a total number would probably exceed that indicated by this report. This is due to lack of facilities for premature care in the home and certain small hospitals, and the difficulties in providing safe transportation of premature infants to hospitals and centers where proper premature care can be given.

Unfortunately the average small hospital, such as included in Groups I and II, does not have the resources nor the trained personnel to provide optimum premature care, and it is doubtful if these services are economically feasible in many instances.

The Premature Care Problem Throughout the State

The problem of premature care and premature death seems to include more than just hospital bed distribution in the various regions of the state. It includes such factors as topography, population, local resources, and transportation. It is absurd to believe that every county in the state can provide itself with a hospital of a size and with such facilities as to provide optimum care for the premature infant. Since premature care is a highly specialized service, requiring expensive and unusual facilities and specially trained personnel, it would seem that we must create regions by grouping counties together in which at least one adequate premature care station can be operated at less than a preventive cost.

In making this analysis we have arbitrarily grouped counties together into certain regions according to existing facilities, economic conditions, and available hospital facilities, in order to point up the need and to help toward a logical solution (Map II). Map II reflects some of the conditions shown in Map I, since we have determined that the death rate from prematurity coincides with the percentage of live births in hospitals, being higher in the areas where hospital facilities are limited and transportation difficult.

If Tables IV and V are studied with regard to the regions shown in Map II, it will be readily noted that the neonatal death rate and the percentage of prematures dying is lower in the larger metropolitan areas and highest in the rural areas remote from any hospital facilities. For example, in the area designated as region Number 10 we have very limited hospital facilities, except for an excellent small general hospital in Lawrence County. In this region we have the highest

TABLE V
HOSPITAL LIVE BIRTHS AND NEONATAL DEATHS IN SELECTED AREAS, INDIANA, 1943-1945

Area	Total Live Births	Neonatal Deaths	
		Number	Rate
1	20,838	395	18.9
2	19,145	280	14.6
3	19,356	319	16.4
4	7,426	127	17.1
5	7,552	147	19.4
6	12,774	228	17.8
7	42,422	663	15.6
8	4,664	102	21.8
9	8,714	183	21.0
10	1,820	45	24.7
11	5,278	111	21.0
12	4,531	85	18.7
13	14,426	288	19.9
Total	168,946	2,973	17.5

neonatal death rate and the highest percentage of infants born prematurely that died during the neonatal period.

From these facts we may conclude that a program to establish completely equipped and staffed premature centers, either in connection with the best existing hospital facilities, or as separate establishments giving a specialized service, would be a forward step in solving this great problem of mortality. The importance of an exclusive premature nursery in a hospital is brought out by Bloxsom,[4] who reports a 51 per cent reduction in premature deaths brought about by the establishment of such a service.

As a necessary adjunct to a premature center program we must include plans for referral of cases, and methods of quick and safe transportation of premature infants from all parts of a region to a center best able to give adequate care. This type of service would require a great deal of effort and expense, but the need represents too great a demand to be overlooked by the people, the medical profession, and the hospitals of the state. Eight states now have premature center services in operation, and others have plans for such services. Indiana should not lag behind in providing this life-saving service.

Summary

We have presented an analysis of some of the maternal and infant care problems in the state based upon statistical data and information provided by the hospitals of the state during the years 1943, 1944, and 1945. From these facts and information we have drawn certain conclusions and we have presented certain recommendations.

We have indicated that there is a great variation in the percentage of births by Cesarean Section in the counties and institutions of the state, and pointed out that this practice is evidently too frequent in certain areas. We have suggested each hospital medical staff should analyze its policies and practices.

We have shown that maternal and neonatal mortality may reflect the facilities and practices in a hospital, and we have concluded that there should be greater care in diagnostic procedures and improvement in management and care in the smaller institutions.

The facts presented clearly indicate the advantages in the well-equipped and better-staffed institutions for the care of the newborn and the premature infant. As regards premature care we have presented a particular analysis of the problem. It was concluded that a feasible method for the control of this most important cause of infant death might be a state-wide program for the establishment of centers for care of premature infants in certain designated geographic regions in the state.

As a final statement we conclude that improvements in all of these matters, and further reduction in mortality and morbidity, will be dependent upon a great increase in hospital facilities and in the numbers of well-trained personnel. There may be controversial points in this report, and we humbly expect some errors, but certainly a challenge is thrown out to our professional groups and institutions.

TABLE VI
PREMATURE BIRTHS AND DEATHS IN HOSPITALS BY SELECTED AREAS, INDIANA, 1943-1945

Area	Number of Premature Births	Number of Premature Deaths	Percent of Prematures That Died
1	765	146	19.
2	598	157	26.
3	622	140	22.
4	250	53	21.
5	232	73	31.
6	569	111	19.
7	1,741	338	19.
8	216	49	22.
9	322	84	26.
10	74	26	35.
11	164	47	29.
12	162	46	28.
13	583	150	25.
Total	6,298	1,420	22.

[4] Bloxsom, A.: Study of Premature Infants Observed in Private Hospital before and after Establishment of Premature Nursery. *J. Ped.*, April, 1946.

LOOPHOLES IN DISABILITY INSURANCE

ALBERT STUMP*

INDIANAPOLIS

Insurance is a highly technical business. The experienced and capable insurance man may be regarded as a professional man. One of the characteristics of a profession is that there develops within it a vocabulary with which the members of the profession become familiar, but with which the layman, with respect to that profession, is not familiar. For that reason the most important guard against undesirable and inadequate insurance protection lies in the selection of an honest and intelligent insurance agent, personally known to you, who is seriously and studiously making insurance his profession. Such a man, knowing that he is likely to have to face you and your friends when the situation arises where you expect the insurance as you understood it to come to your aid, is not likely to overstate the protection afforded in the policy he sells you. He does not want to face the tragic result if you find yourself without the protection for which you thought you had paid. Life insurance agents making that calling a profession do not depend to any great extent on disability insurance. Many life insurance companies do not write it. Therefore, the professionally-minded life insurance agents may be more likely to approach your disability problems without bias or prejudice, but with considerable knowledge regarding the whole subject of insurance protection and with your interests paramount.

TYPES OF POLICIES

To illustrate the difficulties the "insurance layman" may have with the insurance man's professional vocabulary your attention is invited to five types of disability income policies being sold. They are:

1. Cancellable policies in general—which may be cancelled at any time before a claim arises or after a claim has been paid.

2. Non-cancellable term policies—which generally cannot be cancelled for the year for which the premium was paid and accepted by the company, but which can be renewed after the period covered by that premium only with the consent of the company. These policies are likely to be particularly misleading. The company ends its responsibility and terminates the insurance simply by refusing to accept the premium and renew the policy at the end of the year covered by the last premium paid. The reason for calling them non-cancellable is that they cannot be cancelled during the year for which the premium was paid, as may be done with cancellable policies.

3. Non-cancellable renewable policies—on which renewal premiums may be increased above the premiums formerly paid.

4. Non-cancellable renewable fixed-premium policies—which carry definite provisions for increasing the premium in accordance with the increase of the age of the insured and which give the insured the absolute right to renew.

5. Non-cancellable renewable level-premium policies—on which the premium remains unchanged and which the insured has the absolute right to renew.

Because of the possibility of confusion and deception in connection with the sale of non-cancellable policies where right of renewal depends on the consent of the company, some states have prohibited by law the sale of such policies as non-cancellable policies. Too many will not realize that the policy may be ended by the refusal of the company to renew it. The result is the same as if the policy could be and was cancelled.

INSURED AGAINST WHAT?

A technical feature that is almost certain to escape consideration by the layman buying accident insurance is to be found in the insuring clause. That is the part of the policy that states the conditions under which the benefits of the policy are to be paid. These clauses vary in different policies. One of the important questions regarding that clause is whether the company pays because of bodily injury "received through accidental means," or because of "accidental bodily injury." The first clause covers unintended means—that is, the means bringing about the injuries must be unintended. For instance, in Kendall v. Travelers Insurance Company, 87 Oregon 179, the court held that an abrasion by a barber as a result of his attempting to remove ingrowing hair at the request of the insured was not an accidental but was an intended means, and therefore the results of removing the ingrowing hair did not come within the insuring clause.

Another court held that shaking down ashes in a furnace from which the insured was injured was not covered because the means was intentional. In another case it was held that infection arising from rubbing a toe with a towel, which resulted in a bodily injury, did not involve an accidental means.

On the other hand, if the insuring clauses in these disability policies covered "accidental bodily injury" the policies would have covered the injuries sustained.

Another highly technical and often controversial question is, When is a person disabled? Is it only when he is unable to do anything at all, or only when he is confined to his house, or only when he is confined to a bed? If it requires that he be confined continuously within doors, then if he sits in the yard or on his porch or makes an automobile trip his disability benefits are terminated. Suppose a person suffers a stroke of paralysis, as a result

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of which he is impaired to the extent that he cannot carry on his business. If his disability policy contains a house confinement clause he would be compelled to stay in his house for the rest of his life if his financial condition required him to depend on his disability benefits. If disability means inability to perform all the usual tasks connected with his regular profession or employment, one situation exists; but if it means only some one or more essential duty in order to carry on his profession, another situation exists.

The Policy, Not the Advertising, Controls

This should be sufficient to indicate the highly technical elements in insurance. But insurance is often sold by the advertising, by the oral persuasion of the agent, or by the recommendation of some other person who himself may not have taken the time to check the policy against a definite outline for analysis which would disclose its actual merits and demerits. It should be remembered that the insurance company is not bound by the statements of its agents. The policy itself is the contract which establishes the obligation of the company. An analysis of the policy sometimes discloses that the policy falls far short of what the physician or other buyer of insurance thought it was. He listened too intently to the statement of agents or the recommendation of friends, or read the advertising with too much credulity. There is but one means of determining what the company's obligations are, and that is an accurate analysis of the policy itself. If any agent refuses to give you a specimen copy of a policy for study and analysis by one who is competent in that work, you can be sure that there is some reason for withholding the sample policy other than the best interest of the person being solicited.

The physician or other person buying disability insurance should not expect any financial miracles from the company. The company cannot remain solvent if it gives benefits greater than are paid for in the premiums. A few statistics will indicate the limitations on benefits that can be paid where premiums are low enough that the policy can be sold. Disability insurance should be regarded as protection against what might otherwise be a calamity. To go beyond that is inadvisable, as a few statistics will demonstrate. According to reliable statistics there are 662 cases of disability per 1,000 of population each year in the United States; that is, two out of every three are disabled, if by being disabled is meant that one or more days work is lost because of illness or injury. So in the figure 662 will be included everything causing any loss of time, whether for a single day or for an entire life time. Only 75 of the 662 disabilities per year result from accident. The remaining 587 are caused by sickness. Obviously any policy covering policyholders so completely that two out of every three would collect each year under their policies for disabilities ranging from one day to the entire lifetime would require such a prohibitive premium that not enough sales could be made to make the business succeed.

Some Pitfalls In Special Policies

Insurance is a highly competitive business. Occasionally insurance companies try to gain a competitive advantage by making their policies appear to offer more than they really do. They may promise complete protection from the first day of disability and then include exclusions of certain ailments from the coverage. They may permit cancellation of the policy or termination of it by refusing to renew the policy at the expiration of the time covered by the last premium paid. They may pay only while the person is totally disabled or continuously house confined. These mentioned limitations on liability of course do not exhaust the limitations that may be included in a policy which may overemphasize some desirable feature which is more than made up for by undesirable limitations and exclusions.

One of the means by which some companies try to meet competition is by claiming that they are giving group insurance to special classes, when in fact what they are offering does not constitute true group insurance. True disability group insurance is insurance which does not become effective until a certain percentage of the members of the group have subscribed for policies all of the same kind. Thus if a company were to write disability group insurance on the medical association it would be such insurance as would become effective only when some definite percentage of the whole association had subscribed for and been issued the same kind of policy—or, for convenience sake, had issued one master policy with certificates of interest to the individuals in that master policy.

There is a type of group insurance which is sometimes referred to as "franchise group insurance." A franchise, as a matter of law, is a privilege or right which may be granted to one or more but is not given to the whole public. For instance, a policy might be specially worked out for members of the medical profession which other professions or the public at large could not obtain. The company giving the right or privilege—or in legalistic language, the franchise—would not give the same policy to those who were not in the group receiving the franchise from the company. Some insurance companies have attempted to meet competition by marking their regular policies as special policies for some group or other when the fact is that any other group or profession, or even any member of the public at large, could buy exactly the same policy for the same premium. Yet the idea that is implanted in the mind of the member of the profession who looks at an application blank with the words in large letters to the effect that the policy is one available only to those who are members of his particular profession is that he is getting something special—something better than the general public, or those not a member of his group, could get for the same money.

Still another of the means by which companies

seek to make it appear that they are offering something better for a lower price than their competitors offer is to offer a franchise group policy declared to be non-cancellable and renewable without the consent of the company, and then include in that policy exceptions under which all the policies issued to that franchise group may be cancelled or the right of renewal refused. Suppose you obtain a franchise group policy of that kind. The company may carry along and continue to renew the policy until the increase of the average age of those who have obtained such a policy brings the group into the place where there is a heavy cost in carrying the insurance further. Then the company may refuse to renew everybody in that group and all of them will have their disability insurance thereby terminated at a time when they have grown older, been afflicted by disease, and become uninsurable. Just when they need the insurance it may be cut off. This plan could be carried out only partially, by the company writing new policies for those who still continue as desirable risks and then cancelling all the original policies in the original franchise group.

No Association Indorsement of Any Disability Insurance

Because of these elements which affect disability insurance—and similar elements of a like technical nature affecting all other types of insurance—the state association has never indorsed any particular policy nor any particular company, except with respect to malpractice insurance. On malpractice insurance the Committee on Insurance, with the help of insurance men and legal counsel, worked out the form of the policy, and the St. Paul Mercury Insurance Company agreed to issue policies in that form. The committee did not do this until after it had given opportunity to other companies to write the same policy and they had indicated that they were not interested in it.

No company or policy has been indorsed for disability insurance or any other type of insurance, with the exception just stated. If any indorsement were ever to be made by the association of any policy or company there is no doubt but what the program that would be followed by the state association in that event would be for the association to inform the members of their action, and not leave it as a matter upon which the profession would receive information only through the representatives of the insurance company.

Conclusion

This article has been written with the sole purpose of attempting to give to the members of the association at least enough understanding of disability insurance programs that they will realize that these problems fall within a specialized business where service of a professional nature should be had. Fortunately such service is generally available through your own locally established insurance agents who are making of their work a serious profession, or it may be obtained through legal counsel.

SERVICES FOR CRIPPLED CHILDREN

Carl D. Martz, M.D.*

INDIANAPOLIS

FROM the time the state agency known as the Division of Services for Crippled Children was first initiated in 1937 it has been the intent and desire to handle the program of medical care and treatment for indigent crippled children in a manner that is acceptable to the medical profession in Indiana, and also to keep the medical profession advised as to new developments in this field.

During the 1947 session of the Indiana State Legislature two bills were introduced having to do with the crippled children's program. These bills were passed and the first one is now entitled Chapter 201 of the Acts of 1947, an act creating a commission for physically handicapped children and defining its duties, providing for a state-wide census of physically handicapped children, and declaring an emergency. The second one, Chapter 276, Acts of 1947, is an act concerning the education of handicapped children, providing for the excess and certain costs thereof to be paid by the state, creating a Division of Special Education within the State Board of Education, making appropriations therefor, and declaring an emergency.

At a meeting of the council of the Indiana State Medical Association on September 21 a brief summary was presented of the tentative plans worked out by the Division of Services for Crippled Children in carrying on the state-wide survey or census of physically handicapped children, as called for in Chapter 201 of the Acts of 1947 as previously mentioned. This was in order to give the council, as representatives of the medical profession in the state, some idea as to what is contemplated and the reasons therefor.

In the past four or five years, and especially during the period of prosperity which accompanied the increase in employment during the war years, there has been a very rapid growth in the so-called private agencies operating in the crippled children's field with the use of funds collected through public contribution. In addition to these agencies there

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was also a number of official agencies which had to do with different phases of the care and training of physically handicapped children. Until the creation of the Commission for Physically Handicapped Children there was no over-all supervision or control of these related groups, which meant that there was quite a bit of duplication and sometimes competition in the field of service to these children. With the creation of this commission it is hoped that over-all direction and supervision can be given to all these agencies and organizations.

This commission is composed of twelve members, seven of whom are ex officio members representing the state departments of public welfare, board of health, board of education, employment security board, council for mental health, dean of the Indiana University Medical Center, and chairman of the state hospital council. Five members of the commission will be appointed by the governor and at least one of these members shall be a member of the Indiana State Medical Association. From this it is obvious that the medical profession is well represented on this board and should be able, if necessary, to exert quite a bit of influence in formulating policies for the guidance of the commission. In order to have a sound basis upon which to work, it was felt that it would be necessary to have a more adequate register of physically handicapped children than is now available in the files of the Division of Services for Crippled Children. To obtain this information the division has secured the temporary services of a graduate student of Indiana University to carry on the census, which will be handled through the local county and city superintendents of public instruction in each county and city in the state.

This information will then be used in making recommendations for future legislation and services that might be needed in this field. All names of physically handicapped persons will be considered confidential and accessible only to such persons or agencies as are qualified to make use of them. At the present time the only information of this kind is carried in the files of the Division of Services for Crippled Children and is not sufficiently complete or adequate to give accurate information covering the entire state, nor the number of handicapped persons under twenty-one years of age living in Indiana. The information obtained will not be used to broaden any services now provided this group of persons, as adequate service is now available in all fields.

Chapter 276 of the Acts of 1947 was sponsored by a group of persons from Muncie particularly interested in the education of handicapped children. The bill as originally submitted was quite comprehensive and called for the construction of special schools for crippled children throughout the state. It also overlooked the necessity of having medical supervision by the family physician of children attending such schools. No provision was made for proper medical supervision of therapists working in schools created under this act, and it was only through pressure brought to bear by professional persons that amendments were made to this bill before final passage, which eliminated the undesirable features mentioned above.

In order that the medical profession may be better acquainted with its responsibility in regard to Chapter 276, Section 8 of this act is quoted:

> "The medical care of the handicapped child shall be the responsibility of the physician chosen by the family or guardian to attend that child. However, no handicapped child is to be excused from attending school unless the local health officer, upon a statement of the attending physician, certifies that attendance would be injurious to the child. No child shall be admitted without a certificate from the local health officer upon recommendation of the attending physician. No physical, occupational or speech therapy shall be given to the child except as prescribed in writing by the attending physician. The educational and recreational program shall in no way alter the medical care prescribed by the proper medical authority.
>
> "All nurses and special therapists in physical therapy, occupational therapy and speech therapy, and related medical fields shall be graduates of fully accredited training schools and shall be registered by their respective examining boards or by their respective professional associations and shall meet any specifications established for such positions by the Commission for Physically Handicapped Children.
>
> "The medical care of needy children suffering a handicap shall continue to be the responsibility of the State Department of Public Welfare and its Division for Crippled Children Services so far as provided by law. The personnel and facilities of said Division for Crippled Children Services, shall be utilized at all times for the determination of policies related to the medical care of handicapped children, for the professional supervision of all special therapists, and for individual case work as available."

The definition of a crippled child as used in the program of the crippled children's division is as follows:

> "A crippled child shall be defined as a child under twenty-one (21) years of age who, from any cause, is deprived of the free and normal use of any of his limbs or who shall be deprived of strength or capability for service due to bone, tendon, joint or fascial deformity caused by accident, birth injury, or disease; neuro-muscular affection due to disease, birth injury or other trauma; cicatricial scars which limit motion of extremities; or crippling physical defects, congenital or acquired, that may be benefited by surgical or other medical procedures."

No broadening of this definition is contemplated in connection with the two acts which were created

by the 1947 legislature. It is the intention of the division, however, to provide adequate medical care and treatment for all crippled children who fall within this definition and are eligible for service under the state welfare act. In addition to the requirements set out in the definition, the state welfare act provides that an applicant must have lived in the state one year and be financially unable to provide such service out of his own resources before being eligible for aid through the welfare program.

Members of the medical profession in Indiana have contributed much to the services that have been provided these children in the past ten years and we feel sure that many potential tax consumers have been physically rehabilitated to the point where they are able to maintain their place in the economic and social structure of their communities, thus becoming assets instead of burdens to their families and the state.

THE HAZARDS OF BUTCHERING

John M. Palm, M.D.

BRAZIL

DUE to the increased number of frozen food lockers and the increase of home processing of meats which has occurred in Indiana in the past few years, it has come to our attention that there are many hazards to which the individual is exposed.

Aside from the laceration of sharp knives, the scalding burns of boiling water, and the "sniffles" which develop following "Butchering Day" because of the usual cold temperature, there are some hazards that produce more debilitating results. The animals that are processed are, as a rule, home grown and fattened. Many times these animals are selected from large herds, or they are purchased by small land owners and fattened for the purpose of home consumption.

In both of these groups the animals are not given any veterinarian inspection prior to slaughter, wherein lies the danger of handling and processing home killed meat.

In the past year we have found five cases of tularemia, three cases of brucellosis, and two cases of erysipeloid infection. Upon taking a careful history, we believe these came directly from handling and processing infected animals in the process of home butchering.

The cases of tularemia were all of the ulcer glandular type. Two of the cases were brothers who had helped to butcher the same hog, and who developed symptoms within twenty-four hours of each other.

In all instances the hogs had livers which were considered unfit for consumption, due to "spotting and mottling," and were discarded by the butchers. In none of these cases was there a history of having handled any wild game prior to the onset of the disease.

The state veterinarian report states that many hogs are infected with tularemia, due to the fact that the hog, grazing in the field, may ingest an infected rabbit or other game which may have died of the disease.

The cases of brucellosis came from the processing of infected beef. I believe that there are numerous cases in the literature of meat processors in the large packing houses having been infected. The three cases of brucellosis all showed typical onset and symptoms, with both the blood titer and skin tests positive. These cases were all men, and each gave a history of recent handling of fresh meat in process of butchery. One man gave the history of having butchered a cow because the animal would not carry her calves. Another gave the same reason for butchering a sow. In all cases milk consumption was from a family cow, which was not part of the herd, and later proved negative to tests by the state veterinary.

The two cases of erysipeloid infection occurred in two persons who were neighbors, who had assisted one another in their "fall butchering." They both developed the infection upon their hands at approximately the same time.

There was nothing unusual in any of these cases, except in the mode of infection. They all recovered without complications and under the usual treatment. However, due to the approaching season of "home processing" of meat, it is believed that this may call the attention of the medical profession to the fact that these diseases can be contracted from the processing of meat at home. It is recommended that all animals selected for home butchering be inspected by a veterinary prior to the processing. This would greatly lessen the hazard. These cases were reported at the suggestion of the State Board of Health.

ASSOCIATION HONORS VETERAN PHYSICIANS

A NEW and impressive feature of the annual dinner held during the state medical meeting at French Lick October 30 was the presentation of certificates of distinction and gold pins to physicians who have practiced medicine for fifty years or more.

While approximately 175 doctors were eligible to receive these awards, only a few of them were able to be present at the dinner. A number of the veteran physicians are more than 90 years old, one being 97. Dr. Floyd T. Romberger, president of the Indiana State Medical Association, eulogized the oldsters in his presentation speech. Dr. Joseph H. Weinstein of Terre Haute, a past president of the association, responded with appropriate remarks.

The guests of honor were seated at special tables. Their framed certificates served as their place cards. The pins bear the inscription "Fifty Year Club" and the name of the association. The Certificate reads as follows: "Certificate of Distinction, 50 years in the practice of Medicine. This is to certify that John Doe, M. D., has practiced his chosen profession of medicine for Fifty Years, or more, and that through his proficient and untiring ministry of the science of healing has done honor to his God, his community, his profession, and himself. In Recognition of his unselfish devotion to his patients and his loyalty to the medical profession, the Indiana State Medical Association does hereby award him this Certificate of Distinction." Similar awards will be made next year to physicians who have reached the fifty-years-of-practice milestone in 1948.



50-Year Club Membership Emblem



Certificate of Distinction
50 Years
in the practice of Medicine

This is to certify that
John Doe, M.D.
has practiced his chosen profession of medicine for Fifty Years, or more, and that through his proficient and untiring ministry of the science of healing has done honor to his God, his community, his profession, and himself.

In Recognition
of his unselfish devotion to his patients and his loyalty to the medical profession, the Indiana State Medical Association does hereby award him this Certificate of Distinction.

Floyd T. Romberger M. D.
President

October 30, 1947
Ray E. Smith
Executive Secretary

Following is a list of the 1947 "Fifty Year Club" members by county medical societies:

Adams—Amos E. Reusser, Berne.

Allen—John E. Bickel, Fort Wayne; Willis W. Carey, Fort Wayne; Calvin H. English, Fort Wayne, and Martin F. Schick, Fort Wayne.

Bartholomew—Orville A. Delong, Elizabethtown, and Lewis D. Reed, Hope.

Benton—David E. Mavity, Fowler.

Boone—Elmer D. Johns, Zionsville; Richard F. King, Jamestown, and Jesse E. Tucker, Elizaville.

Carroll—Charles C. Crampton, Delphi.

Cass—William Holloway, Logansport, and John B. Maxwell, Logansport.

Clark—John H. Baldwin, Jeffersonville.

Clinton—Stephen B. Sims, Frankfort, and William H. Wisehart, Colfax.

Daviess-Martin—Solomon L. McPherson, Washington, and Mac Guyer Porter, Elnora.

Dearborn-Ohio—William F. Duncan, Aurora, and Arthur T. Fagaly, Lawrenceburg.

Decatur—William D. Harvey, Burney; Eden T. Riley, Greensburg, and Ira M. Sanders, Greensburg.

DeKalb—Charles S. Stewart, Auburn, and Willard W. Swarts, Three Rivers, Michigan.

Delaware-Blackford—George F. Ames, Eaton; Herbert D. Fair, Muncie; Arthur T. Kemper, Muncie, and James A. Taylor, Montpelier.

Dubois—Louis C. Lukemeyer, Huntingburg.

Elkhart—Fred N. Dewey, Elkhart; Moses A. Farver, Middlebury; Benjamin F. Kuhn, North Webster; Willard Price, Nappanee, and Edwin D. Stuckman, New Paris.

Fayette-Franklin—Stanton E. Gordin, Connersville.

Floyd—Dudley F. Davis, New Albany; Henry B. Shacklett, New Albany, and William C. Winstandley, New Albany.

Fulton—George E. Hoffman, Rochester; Milo O. King, Rochester, and Loring C. Meek, Rochester.

Gibson—George B. Beresford, Owensville; Marshall P. Hollingsworth, Princeton, and Hilbert P. Klein, Fort Branch.

Grant—Aaron D. Burge, Marion; Lindley H. Eshelman, Marion; Glen D. Kimball, Marion; James D. McKay, Marion, and Nettie B. Powell, Marion.

Greene—James S. Simons, Lyons.

Hamilton—Joseph L. Hicks, Arcadia, and Carlton H. Tomlinson, Cicero.

Hancock—Oscar S. Heller, Greenfield, and Charles R. Titus, Wilkinson.

Henry—Ralph Wilson, Shirley.

Howard—William H. Harrison, Kokomo; LaMarr Knepple, Kokomo, and John F. Powell, Greentown.

Huntington—Fred W. Grayson, Huntington.

Jackson—James M. Jenkins, Cortland.

Jay—John J. Kidder, Salamonia; William D. Schwartz, Portland, and William H. Walker, Portland.

Jefferson—Charles C. Copeland, Madison; Nicholas A. Kremer, Madison, and Schuyler A. Whitsitt, Madison.

Jennings—David W. Robertson, Deputy, and William H. Stemm, North Vernon.

Johnson—David L. Phipps, Union City.

Knox—Norman E. Beckes, Vincennes; Adam B. Knapp, Vincennes, and John P. Ramsay, Vincennes.

Lawrence—Charles H. Emery, Bedford.

Lake—William P. Alexander, Gary; Antonio Giorgi, Gary; Aron J. Lauer, Whiting; Charles B. Matthews, Hammond, and William E. Nichols, Hammond.

LaPorte—Edward G. Blinks, Michigan City; Alva L. Spinning, Michigan City; William Walkinshaw, Stillwell, and Frank R. Warren, Michigan City.

Madison—Maynard A. Austin, Anderson; Etta Charles, Anderson; Ernest M. Conrad, Anderson; John J. Gibson, Alexandria; William H. Hoppenrath, Elwood; Frank G. Keller, Alexandria; James A. Long, Anderson; Anthony E. Otto, Alexandria; Monroe L. Ploughe, Elwood, and Daniel S. Quickel, Anderson.

Marion—Max A. Bahr; Charles R. Bird; John J. Boaz; Elmer H. Brubaker; Elizabeth S. Conger; Charles J. Cook; Bernhard Erdman; Sumner A. Furniss; Norris E. Harold; Orville S. Jaquith; Norman E. Jobes; Edwin S. Knox; Douglas A. Leathers; John M. Lochhead; C. B. McCulloch; Charles M. McNaull; William F. Molt; Joseph E. Moutoux; Oliver C. Neier; Thomas B. Noble, Sr.,; Thomas A. O'Dell; Fred L. Pettijohn; Charles A. Pfafflin; C. Richard Schaefer; John W. Sluss; Lewis A. E. Storch; Charles F. Voyles; Julius O. Wehrman; John T. Wheeler; Luther L. Williams; Lazarus L. Witt, all of Indianapolis, and Alois B. Graham, Ligonier, Pennsylvania.

Marshall—Charles F. Holtzendorff, St. Petersburg, Florida, and Robert C. Stephens, Plymouth.

Miami—Frank M. Lynn, Peru; David C. Ridenour, Peru, and John E. Yarling, Peru.

Montgomery—Thomas Z. Ball, Crawfordsville; Harry M. Bounnell, Waynetown, and Thomas L. Cooksey, Crawfordsville.

Noble—Columbus B. Goodwin, Kendallville; Charles F. Hardy, Kendallville; John W. Morr, Albion, and William M. Veazy, Avilla.

Orange—Robert E. Baker, Orleans.

Owen-Monroe—Fred H. Austin, Bloomington; John E. Luzadder, Bloomington; Robert C. Rogers, Bloomington; James W. Wiltshire, Bloomington, and Boaz Yocum, Coal City.

Perry—William T. Hargis, Tell City.

Pike—Loranza D. Goodwin, Winslow; John T. Kime, Petersburg, and Thompson R. Rice, Petersburg.

St. Joseph—Harry Boyd-Snee, South Bend; John T. How, Lakeville, and Harry F. Mitchell, South Bend.

Shelby—Gustus S. Billman, Shelbyville; M. Joseph Coomes, Shelbyville; Emil G. Grove, Shelbyville, and Samuel Kennedy, Shelbyville.

Spencer—Eva J. Buxton, Rockport.

Starke—James L. DeNaut, Hamlet.

Steuben—William H. Lane, Angola.

Switzerland—Lowery H. Bear, Vevay, and George W. Copeland, Vevay.

Tippecanoe—George W. Dewey, La Fayette; Charles Hupe, La Fayette, and John S. Morrison, La Fayette.

Vanderburgh—William E. McCool, Evansville.

Vigo—Ezra R. Baldridge; Abram L. Cabell; Earl S. Niblack; Joseph H. Weinstein; Frank E. Weidemann; John R. Wilson; Charles Wyeth, all of Terre Haute, and Charles M. DuPuy, Riley.

Wabash—Noah Thompson, Bedford, Virginia, and Joseph L. Warvel, North Manchester.

Warrick—Charles E. Springstun, Tennyson.

Washington—Lawrence W. Paynter, Salem.

Wayne-Union—Charles S. Bond, Richmond; Amos E. Ehle, Richmond; Joseph H. Kinsey, Richmond; Rolla B. Ramsey, Richmond; Joseph N. Study, Cambridge City, and Martin W. Yencer, Richmond.

White—Henry W. Greist, Monticello.

Voice of Medicine

Dear Doctor Shanklin:

In connection with the recent interest in the General Practice of Medicine and the continuing tendency of young graduates to go into narrow specialties, I thought that you might be interested in my own experience in this matter.

We have done a great deal in the way of General Practice Boards, the Academy of General Practice, scholarships for those going into general practice, et cetera, et cetera, but it is still an inescapable fact that the advantages inherent in specialization are going to serve as a constant temptation to medical students and young physicians. This has been made more than ever true recently, by the emphasis the armed services and the Veterans Administration have placed upon specialty certification. No amount of editorial deploring, committee formation, or resolution writing is going to change this. The steps which have been taken so far are excellent, particularly those directed towards recognition of the general practitioner in hospitals and clinics. This will go far toward encouraging young men to continue in general work. The Sections on General Practice in state and national organizations also serve to promote proper recognition.

One may well ask, "What is wrong with the specialist? Is it his high fees, his inability or disinclination to deal with simple medical problems, or is it his ivory tower isolation?" Certainly no one can dispute the fact, particularly in this complicated modern world, that any special field of medicine can be better understood and better handled by a man who has made a special study of it. It is my own opinion that much of the criticism directed toward the specialist, both by general practitioners and by patients, comes from the fact that he is a relatively unapproachable man, located in a large city, seeing patients only by often-difficult-to-get appointments, whose only contact with the general practitioner is by letters, which are sometimes singularly uninformative.

Would specialization be viewed in a different light if more specialists lived in relatively small towns and cities, were easier to reach, attended the local county societies, and were seen in the wards of the small county seat hospitals? Up to this time few specialties have apparently lent themselves to small town practice. Eye, ear, nose, and throat has been the only noteworthy exception, although in a few instances general surgeons have practiced in county seat towns without engaging in general practice.

Because my own experience may be pertinent in this matter I felt that you might be interested. As you know, Mentone is a town of 700, approximately fifty miles from Fort Wayne and South Bend. I came here in 1937, after two years of training in Internal Medicine, and engaged in general practice until 1942. Then, because of ill health, I decided to limit my work to Internal Medicine, and was eventually able to achieve my certification in Internal Medicine and, later, in the subspecialty of Cardiovascular Diseases. I was also elected an Associate of the American College of Physicians at its last meeting. I have, then, all the degrees, diplomas, and certificates necessary to set myself up as a specialist wherever I may choose. For reasons of my own I have chosen to stay in Mentone. My practice is limited to Internal Medicine, with emphasis on Cardiovascular Diseases and on my special interest, Brucellosis. The doctors in the surrounding towns have supported me well, and up to this time I have found no reason why I cannot practice my desired specialty in this village as well as I could in a much larger place. In addition, and this is the only real justification for calling attention to this successful experiment, I am readily accessible to the people of this community. I am still the family doctor for many people, although they know that if they get a broken bone, need an appendectomy, or have a baby, they must go to someone else. I have kept my fees for routine services low, although my charges for true specialty work, consultations, examinations, et cetera, are on a level with those charged by internists in Fort Wayne and South Bend. This experience has been a happy one for me and I think that it has been for my friends, both patients and doctors.

The point, then, is this: should we not place more emphasis on the fact that specialties can be profitably practiced in small communities? Perhaps no one will care to come to a town of 700, but there are certainly many county seat towns of 5,000 to 10,000 population which could well support a pediatrician, EENT man, surgeon, or internist. Towns of somewhat larger size should provide good opportunities for obstetricians and gynecologists, for neurologist-psychiatrists, for urologists. It appears to me that some publicity in this direction would be worth-while.

Pardon all the speech making! I feel quite strongly about this, and thought that you would be interested.

Yours sincerely,
Dan L. Urschel, M.D.

News Notes

Dr. Clem H. Elshout has announced the opening of an office for the general practice of medicine at 1002 Indiana Avenue, LaPorte.

Dr. James H. Huyck has announced his association with Drs. Oran Province and William Province in the practice of medicine in Franklin. Dr. Huyck is a veteran of Navy service in World War II and until recently was chief resident in medicine at the Mary Imogene Bassett Hospital, in Cooperstown, New York.

Following the completion of a postgraduate course at the Harvard University School of Medicine, Dr. Charles H. Klamer has opened an office in Jasper for the practice of medicine and surgery.

Dr. A. B. Knapp, of Vincennes, recently retired from the practice of medicine. His retirement marks the end of fifty-five years in his profession.

Following his recent discharge from service where he was a flight surgeon, Dr. Frank H. Miller has opened an office for the general practice of medicine at Morristown.

John B. Twyman of East Chicago has become executive secretary of the Lake County Medical Society, succeeding Rollis S. Weesner, who assumed the executive secretaryship of the Indiana Cancer Society on November 1. Mr. Twyman, age 33, was assistant secretary-manager of the East Chicago Chamber of Commerce. He is a graduate of Indiana University and a veteran of World War II.

Dr. Fred M. Blix, formerly of Chicago, has announced the opening of an office in Ladoga for the general practice of medicine.

Announcement has been made by Dr. Crist Blassaras of the opening of an office for the general practice of medicine at 2005 Broadway, Anderson.

Dr. Paul Burns, Montpelier, has been appointed as Blackford County health officer, to fill the unexpired term of the late Dr. T. J. McKean.

The Indiana Association of the History of Medicine met at the home of Dr. and Mrs. Edgar F. Kiser, in Indianapolis, on October first. The speaker for the evening was Dr. William Loehr, of Indianapolis, who discussed "The Great French Clinicians of the Early Nineteenth Century." There was also an exhibit of old medical books used by the French doctors.

Urology Award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, Massachusetts, May 17-20, 1948.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before March 1, 1948.

Dr. F. S. Crockett of LaFayette, chairman of the Committee on Rural Medical Service of the American Medical Association, spoke at the annual dinner of the Kentucky State Medical Association in Louisville on September 30. Ray E. Smith, executive secretary of the Indiana State Medical Association, also attended the Kentucky meeting.

Dr. Okla W. Sicks, of Indianapolis, has moved to 1010 Hume Mansur Building, where he will continue his practice of surgery.

The following letter has been received from Dr. H. G. Weiss, of Evansville, who is on a six month's inspection tour of hospitals of the Board of International Missions of the Evangelical and Reformed Church, in China and India:

"Through the courtesy of the Surgeon General's office I was permitted to spend a day with our medical personnel in Japan. Under their direction I visited Yokohama and Tokyo and our 49th General Hospital, formerly St. Luke's Hospital, Episcopalian, with 500 beds. Had been stripped by the Japanese, but is now fairly well equipped. Both cities suffered severely from our bombing and resulting fires, and now from deficient food and equipment and instability of their monetary system.

"Most of the physicians and surgeons here are British. I find them a fine lot, approachable, intelligent, and courteous. Had Sunday dinner with Dr. Gray, chief surgeon of Queen Mary Hospital (the best hospital in Hong Kong) and professor of surgery of Hong Kong Medical College, F.C. of S. England, F.A.C.S. His guest at his home. Tuberculosis is their great problem. Find Oriental Medicine up-to-date but equipment deficient."



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to the correction of simple constipation involves the reeducation of the normal bowel reflexes.
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Here are the 3 members of the group to date:

1. *Hematest*

Tablet method for rapid detection of occult blood in feces, urine and other body fluids. Bottles of 60 tablets supplied with filter paper.

2. *Albutest*

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Tablet, *no heating* method for quick qualitative detection of albumin. Bottles of 36 and 100.

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Tablet, *no heating* method of detection of urine-sugar.

Laboratory Outfit (No. 2108).

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All products are ideally adapted to use by physicians, public health workers and in large laboratory operations.

Complete information upon request. Distributed through regular drug and medical supply channels only.

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ELKHART, INDIANA

Miss Barbara Boyer, of Indianapolis, and Dr. Phillip E. Pennington, of Bloomington, were united in marriage on August twenty-ninth in Indianapolis. Dr. and Mrs. Pennington will reside in Indianapolis as Dr. Pennington is serving his internship at the Methodist Hospital.

Dr. Walter T. Flaherty, formerly of Louisville, has joined the staff of the Warren Clinic, in Michigan City. Dr. Flaherty is a specialist in diseases of the eye, ear, nose and throat.

THE JOURNAL offers congratulations to Dr. J. T. How, of Lakeville, who recently observed his fiftieth anniversary in the medical profession.

1947 EDITION OF PARERGON

Parergon (work by the side of work) is Mead Johnson & Company's picture book of artistic works by physicians.

The current edition is a book of 208 pages and shows 1100 examples of creative art by contemporary physicians.

This book is available without charge only to physicians upon request of Mead Johnson & Company, Evansville 21, Indiana.

More than four hundred persons attended a testimonial dinner in honor of Dr. Roscoe L. Sensenich, president-elect of the American Medical Association, at the Indiana Club in South Bend, October 8, 1947.

Glowing tributes were paid to Doctor Sensenich by the speakers, who were Dr. Floyd T. Romberger of LaFayette, president of the Indiana State Medical Association; Dr. Ernest R. Irons of Chicago, secretary of the Board of Trustees, American Medical Association; Dr. Elmer L. Henderson of Louisville, Kentucky, chairman of the A.M.A. Board of Trustees; and Dr. Morris Fishbein of Chicago, editor of The Journal of the A.M.A.

Dr. Sensenich's executive ability, his knowledge of finances, his sound judgment, and his level-headedness were stressed by the speakers as they emphasized the great contribution he has made to American Medicine.

After a certificate of appreciation had been presented to him by Dr. Robert B. Sanderson, chairman of the Board of Trustees, St. Joseph County Medical Society, on behalf of the society, Doctor Sensenich responded with appropriate words of thanks.

The dinner was sponsored by the St. Joseph County Medical Society. Dr. Harold D. Pyle, president, presided. Guests included physicians from nearby counties and officers of the state medical association and the American Medical Association.

Doctor Sensenich is the third Hoosier to head the A.M.A. Others were Dr. Theophilus Parvin of Indianapolis, in 1879, and Dr. James F. Hibbard of Richmond, in 1894.

Robert W. Currie, M.D., formerly associated with Dr. D. C. McClelland of Lafayette, has gone to New York City. He has received a year's fellowship in radiology at Memorial Hospital on malignant and allied diseases.

Dr. David Hadley, of Indianapolis, has been awarded a fellowship in orthopedic surgery at the General Hospital by the Marion County chapter of the National Foundation for Infantile Paralysis.

Announcement has been made by Dr. Frank H. Miller, of the opening of an office in Morristown for the general practice of medicine.

Dr. J. M. Klaus, who has been working with the Veterans' Administration, in Indianapolis, has announced his association with Dr. William R. Troutwine, with offices at 224 South Court Street, Crown Point. Dr. Klaus is a veteran of World War II, having served in the army medical corps with the rank of captain.

Dr. Walter Stoeffler, of Indianapolis, has accepted a position with the Veterans Administration in California, and moved there with his family in October. His address is "Veterans Administration Hospital, 13th and Harrison Streets, Oakland 12, California."

Nurses Scholarship Awards

Scholarships worth $200 a year have been awarded to eight nursing school students by the Indiana State Medical Association and Mr. and Mrs. Herman C. Krannert, of New Augusta.

The names of the students and the hospitals where they are in training are:

Miss Barbara Anne Ketterman, 946 W. Main Street, Madison, Methodist Hospital, Indianapolis.

Miss Glenna Jean Martin, 1515 Rembrandt Street, Indianapolis, General Hospital, Indianapolis.

Miss Viva Joan Fisher, 223 E. Superior Street, Lebanon, Indiana University Training School for Nurses, Indianapolis.

Miss Dolores Marie Wedge, R. R. 1, Bristol, St. Joseph Hospital, Mishawaka.

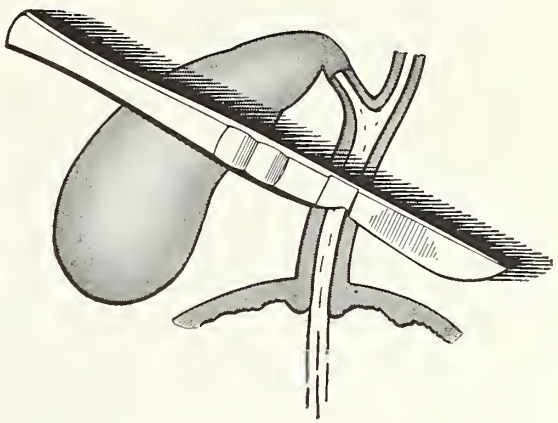
Miss Betty Lou Davis, 4633 Spatz Avenue, Fort Wayne, St. Joseph Hospital, Fort Wayne.

Miss Betty Theresa Simon, 4735 Ash Avenue, Hammond, St. Margaret Hospital, Hammond.

Miss Alice Frances Hanselman, 28 W. Pennsylvania Street, Evansville, St. Mary's Hospital, Evansville.

Miss Carolyn Janeice Goodnight, Kempton, St. Joseph Memorial Hospital, Kokomo.

Misses Ketterman and Martin are recipients of the Krannert scholarships, which are financed by Mr. and Mrs. Krannert through the medical association. The other six scholarships were created recently by the Council of the association.



Surgical Principle Accomplished Medically

Drainage in the presence of infection or congestion is a sound surgical principle.

In chronic inflammatory conditions of the bile passages without stones, drainage is accomplished by increasing the production and flow of free-flowing, low viscosity bile, employing Decholin for its hydrocholeretic action.

Decholin (dehydrocholic acid) stimulates the production of thin bile by the liver cells, with a resultant cleansing action on the entire biliary tract.

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AMES COMPANY, Inc.

ELKHART, INDIANA

A. M. A. to Honor General Practitioner

The Board of Trustees of the American Medical Association recently announced that it has established a special gold medal for a general practitioner who has rendered exceptional service to his community. The award, similar to the American Medical Association's Distinguished Service Medal, which has been given annually since 1938 for scientific advancement in the field of medicine, will be given to a general practitioner for the first time at the supplemental session of the House of Delegates at Cleveland, Ohio, on January 7, 1948. The medal, which will be known as "the medal of the American Medical Association for exceptional service by a general practitioner," will be designed especially for the general practitioner who has served his people as a family physician and who does not devote himself exclusively to a specialty in medicine.

Nominations for the award may be submitted to the headquarters office of the American Medical Association in Chicago by any state medical association or community service club. The nomination should include the name and address of the physician, his scholastic record, and a record of his medical service in the community.

Nominations will be submitted to the executive committee of the Section on General Practice of Medicine of the American Medical Association. This committee will select five leading candidates for nomination for submission to the Board of Trustees which in turn will nominate three of these to the House of Delegates. On the opening day's meeting at the supplemental session the House of Delegates will choose by ballot the general practitioner who will receive the medal.

Following is a list of the initiates from Indiana who were accepted into fellowship at the Thirty-Third Convocation of the American College of Surgeons held in New York on September twelfth:

J. Stanley Battersby, Ralph E. Blackford, Don D. Bowers, Charles F. Gillespie and Russell W. Lamb, all of Indianapolis; William M. Cockrum, Alvin E. Newman, and Howard C. Slaughter, all of Evansville; William Deutsch, Muncie; Marion J. Eaton, Lafayette; Virgil McCarty, Princeton; Don M. Mattox, Terre Haute; Carl J. Rudolph, and Frank M. Scott, of South Bend; Paul W. Sparks, Winchester.

Regional Meeting of American College of Physicians

There will be a Regional meeting of the American College of Physicians at the Schroeder Hotel, Milwaukee, Wisconsin, Saturday, November 15. This regional meeting includes the states of Indiana, Illinois, Michigan, Minnesota, and Wisconsin.

Indiana Tuberculosis Association Scholarship

For those who are not now specializing in tuberculosis but who would like to do so, there is a scholarship available for $100 at a course on thoracic diseases which will be held in Detroit next spring. The school and the time have not yet been selected. This will be a one-week postgraduate course. The State Association will offer several of these scholarships to those who are interested.

All applications are to be sent to the Indiana Tuberculosis Association, Room 1219 Security Trust Building, 130 East Washington Street, Indianapolis.

American Academy of Allergy Convention

The American Academy of Allergy will hold its annual convention at Hotel Jefferson, St. Louis, Missouri, December 15-17 inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy by registering without payment of fee. The program, the scientific and technical exhibits have been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Round table conferences will be held on Monday afternoon, December 15, 1947. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Charles H. Eyermann, M.D., 634 North Grand Boulevard, St. Louis, Missouri.

American Academy of Dermatology and Syphilology Meeting

The sixth annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago, December 6 through December 11. The principal sessions will be held at the Palmer House, with special courses in histopathology and mycology scheduled for December 6 and 7, at the Medical Schools of the University of Illinois and Northwestern University. Teaching clinics will be held at the University of Illinois College of Medicine in Chicago on the afternoons of December 8, 9, and 10.

Special courses in histopathology, mycology, x-ray and radium therapy, bacteriology of the skin, mucous membrane lesions, industrial dermatoses, specific granulomata, and dermatoscleroses will be held under leaders in these various fields.

Subjects to be discussed in symposia will include: physiology and chemistry of the skin; physical and radiation therapy; cutaneous allergy; syphilis; pharmaceutical therapeutics; and diagnostic methods in dermatology. Other features will be a round table discussion on dermatopathology and a panel on management of skin diseases.

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Exploration

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PRIODAX is rarely eliminated prematurely from the gastrointestinal tract. The opacities produced by it are homogeneous, sharp and unstratified. Moreover, clear visualization will not be obscured by contrast substance in the colon when PRIODAX is used. PRIODAX, therefore, provides maximum dependable concentration of the most desirable type for reliable interpretation.

PRIODAX Tablets, beta-(4-hydroxy-3,5-diiodophenyl)-alpha-phenyl-propionic acid, available as six 0.5 Gm. tablets in individual cellophane envelopes. Boxes of 1, 5, 25 and 100 envelopes.

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Motion Picture Films

To assure the listing of all outstanding medical and surgical motion picture films in the revised "Catalogue of Professional Motion Picture Films" now being compiled, all film authors **are urgently** requested to immediately write for film questionnaires to be filled out and returned. All members of the profession are invited to co-operate with this undertaking by forwarding this announcement to an author or by furnishing the film title and full name and address of any film author. Send information to: Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

Your Directory Information Card

Preparations are now being made to publish the new, Eighteenth Edition of the *American Medical Directory!* The last edition of the Directory was issued late in 1942. Since that time, it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

About November 15, a directory card will be mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly whether or not any change has occurred in any of the points on which information is requested. It is urged that those physicians also fill out the right half of the card, which information will be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, mail the card promptly to insure the accurate listing of his name and address. There is no charge for publishing the data nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Therefore, should any physician fail to receive one of these Directory Information cards by December 1, he should write at once to the Directory Department requesting a duplicate card be mailed.

Dr. Chester A. Stayton, of Indianapolis, has announced the association of Dr. James C. Katterjohn with him in the practice of radiology, at 313 Hume Mansur Building, effective November first. Doctor Katterjohn is a diplomate of the American Board of Radiology, having trained at the Memorial Hospital in New York City, and the University of Pennsylvania at Philadelphia.

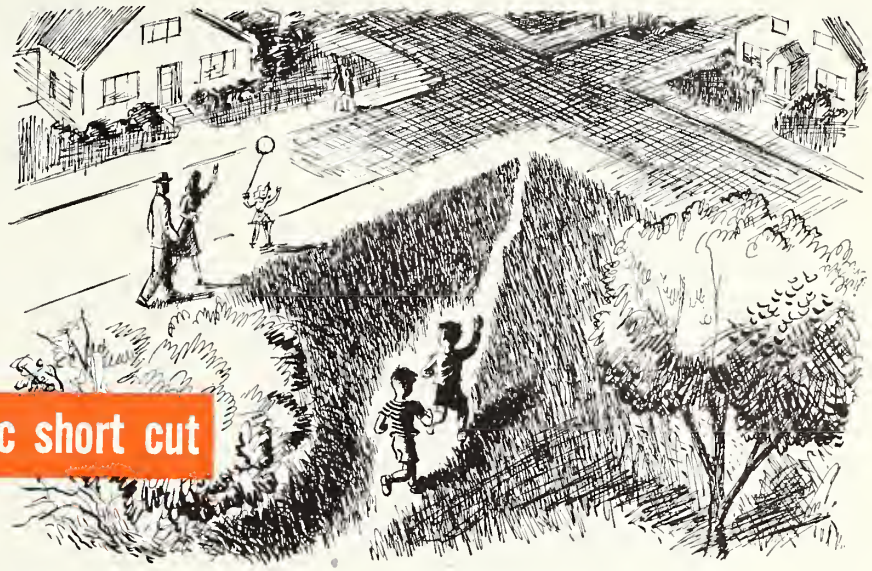
The Indianapolis Obstetrical and Gynecological Society held its first scientific meeting on the evening of October 22. It was a dinner meeting at the Athenaeum, and the program consisted of the following: "Low Spinal Anesthesia in Vaginal Delivery, A Preliminary Report on Two Hundred Consecutive Cases," by Dr. L. H. Allen, Bedford; "The Menopause," by Dr. David A. Bickel, South Bend; "Ectopic Pregnancy—Its Diagnosis and Treatment," by Dr. Ira Cole, Lafayette. Dr. Fred L. Adair of Chesterton, Indiana, was voted in as an honorary member. The next meeting will be held in January, and the program will consist of an address by a guest speaker.

INDIANA UNIVERSITY NEWS NOTES

Revival of the Postgraduate Course by the Indiana University School of Medicine (Oct. 6-10) after a four-year lapse during the war years, brought 187 general practitioners to the medical center campus for lectures, clinics, and discussions of the newer methods of treatment and modern diagnostic measures.

The record-breaking attendance and the interest shown in the program were accepted by Dean John D. VanNuys and Dr. Cyrus J. Clark, chairman of the school's Department of Postgraduate Instruction, as indicating a desire on the part of the physicians for continuance of the Postgraduate Course.

Evening sessions, addressed by Major-General Paul R. Hawley, Dr. James L. Wilson, Dr. Bradley M. Patten, Dr. Conrad Lam, and Captain George Raines, U.S.N., were highlights of the week.



"...physiologic short cut

...sparing the need for digestion and absorption in the gastro-intestinal tract."[1]

"(Parenteral) Amino acids find their greatest usefulness preoperatively and postoperatively in the treatment of patients with gastrointestinal disease."[2]

"Complete parenteral feeding has the advantage of producing complete gastrointestinal rest, equal if not superior to that induced by morphine."[3]

Parenamine

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FOR PROTEIN DEFICIENCY

PARENAMINE is a 15 per cent sterile solution of all the amino acids known to be essential for humans, derived by acid hydrolysis from casein and fortified with *dl*-tryptophane.

PARENTERALLY ADMINISTERED, Parenamine replenishes depleted protein reserves, compensates for the increased loss of nitrogen which accompanies surgical trauma,[3, 4] restores and maintains positive nitrogen balance while resting the gastro-intestinal tract, prevents gastro-intestinal edema, enhances wound healing and shortens convalescence.

FOR USE alone or as a supplement to high protein diets and/or tube feedings to provide the nitrogen essential for normal cell function and tissue repair. *Particularly indicated* in pre- and postoperative management, gastro-intestinal obstruction, extensive burns, etc.

ADMINISTER diluted with three or four parts of 5 per cent dextrose or sterile, pyrogen-free distilled water, isotonic saline, or Ringer's solution.

SUPPLIED AS Solution 15% in 100 cc. rubber-capped bottles.

1. Editorial: J. A. M. A. 121:346, 1943
2. Nadal, J. W.: Northwest Med. 46:444, 1947
3. Sprinz, H.: M. Clin. North America 30: 363, 1946
4. Brunschwig, A., Clark, D. E., and Corbin, N.: Mil. Surgeon 92:413, 1943

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Frederick Stearns & Company Division DETROIT 31, MICHIGAN

Medical Panorama by the Associate Editor

WESTCHESTER COUNTY (New York) advocates the institution of "Medical Expense Insurance for Physicians," in order to assure better medical care for physicians and their families, "without the sense of obligation and embarrassment which has seriously interfered with their medical care in the past." They suggest commercial insurance company underwriting of a plan under the supervision of the A.M.A. as a means of providing "complete and impersonal coverage."

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NEBRASKA points a "lesson in free medical care." In August 1946 a special session of the unicameral legislature passed an Act allowing cash benefits for unlimited medical, hospital, and dental care by a doctor of their choice to assistance clients, in addition to their regular allotments. In less than six months it became evident that the program would soon wreck the system of relief, and medical college dispensaries were threatened with closure. In spite of the small number of clients in these times, the program had to be discontinued because of the economic burden. The desire to "get something for nothing" was indicated as a prominent cause for abandonment of the program. The experience illustrated "the impracticability of throwing the gates wide open in a system of 'free' medical care."

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NEW ENGLAND *Journal of Medicine* deplores the tendency in medical writing to emphasize the short, concise type of presentation with illustrative tables or charts to the neglect of the colorful, descriptive sequence of events that make for interesting and enjoyable reading. The epidemic of "secretarial bibliography" and the "punch-card article" are likewise regrettable. "As one contemplates the volcano of medical literature erupting from the universities, clinics and laboratories of this country, one cannot but express the hope that clinical articles will be written with imagination and color, that they will give a graphic and frank picture of the problems of disease or therapy, the bad shown with the good and the poor results with the cures, and that material relating to laboratory investigations of fundamental nature will be presented with the utmost simplicity and a minimum of confusing data, without apology or pipe-dream exploration of the future. And lastly, it is hoped that the secretarial bibliography and punch-card article will be used sparingly and to good purpose rather than as a method of showing off the thoroughness of the authors' investigative devices." Amen!

WEST VIRGINIA suggests that every member of their State Association "spend five minutes each day discussing with one patient the evils of socialized medicine. The possibilities of enlisting solid support at home are unlimited. Support at home definitely means needed support in Washington. Participation by all the doctors in active practice in the United States would undoubtedly result in speeding the day when the threat that has been hanging over Medicine for these many years would be but a memory."

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REPORT NUMBER 786, House of Representatives, Committee on Expenditures in the Executive Departments, "finds that at least six agencies in the executive branch are using government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States." They are:

1. The U. S. Public Health Service;
2. The Office of Education;
3. The U.S. Employment Service;
4. The Department of Agriculture; and
5. Bureau of Research and Statistics, Social Security Board.

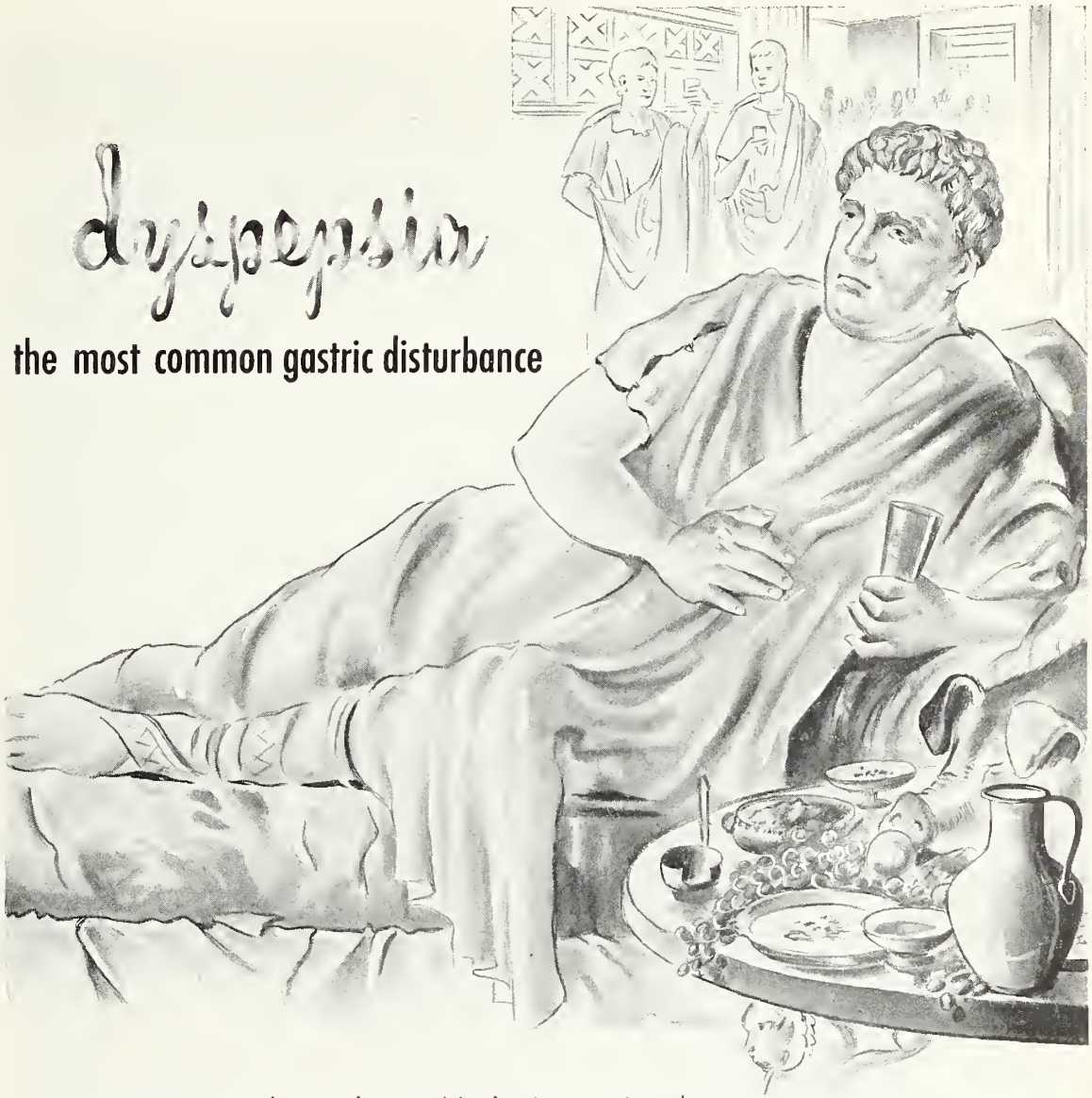
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CONNECTICUT discusses "The Practitioner of General Medicine" in no uncertain terms. Their House of Delegates passed a resolution to the effect "that the criterion of whether a doctor may be a member of a staff or head of a department shall be his actual ability as a doctor, and not dependent on special society or board membership."

They further feel: "That an unwholesome separation of the practitioner of general medicine and the specialist has become even a matter for discussion bodes no good for American Medicine if correction is not made at once. That specialists are physicians first and specialists second are probably trite words, but it is certain that that which concerns medicine concerns every physician, specialist or not. The specialist who has interest only in his own field of medicine is pursuing a narrow and unintelligent course which will inevitably result in mental isolation and, finally, stagnation. As a professional group we must realize that neither by words nor by resolutions can we affect the social status of the practitioner of general medicine. He needs no change in his position, but he does deserve a sincere recognition of what he is and the truly important and essential contribution he has made and is making in our social economy."

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What's Going On In Indiana by the Executive Secretary

More Fun In Indiana. Our annual state session provides more entertainment for physicians and their wives than do other state medical meetings. This is from personal observation and a check of their session programs. In providing this relaxation, Indiana is not slighting its scientific program. Ours is as good as any, and much better than most of them. Entertainment after the annual dinner, either in the form of a floor show or a humorist speaker, is about the only fun at other state meetings. Everybody enjoyed the entertainment Tuesday night, October 28, and it was good to see physicians relax and have a good time. "All work and no play makes Jack a dull boy," so runs the adage, and we believe that doctors need a little fun as much as they do instructional courses and scientific lectures at our annual sessions.

——ISMA——

Board Appoints Investigators. Two investigators have been hired by the Indiana Board of Medical Registration and Examination to collect evidence against violators of the medical practice act. Ethical practitioners in every branch of the healing arts should welcome this announcement. For twenty years the state has been without funds to enforce the medical practice law. The annual registration law was passed by the 1947 General Assembly to provide the board with money to enforce the law it is called upon to administer. The registration law has supplied the board with a list of licensed practitioners and the machinery to prosecute the quacks. In due time the state should be rid of medical charlatans.

——ISMA——

General Practitioners' Program. The American Medical Association is going to give greater recognition to the general practitioner. Its House of Delegates voted to hold the mid-winter meetings at some city other than Chicago and to augment them with a two-day scientific session devoted exclusively to general medicine. The first such program will be given at Cleveland, Ohio, Wednesday and Thursday, January 7 and 8, 1948. The Board of Trustees and the Council on Scientific Assembly will arrange the program. This meeting will follow a two-day session of the House of Delegates, and is expected to draw heavily from the Middle West. Its purpose is twofold: (1) To hold good scientific programs in various parts of the country for the convenience of general practitioners, and (2) to reduce attendance at the annual A.M.A. session in the summer by offering this scientific program in the winter.

——ISMA——

Reason to be Proud. The success of Mutual Medical Insurance, Inc., the prepayment medical care insurance company organized by authorization of our House of Delegates, should cause every Indiana physician to swell with pride. The company's achievements were reviewed by Dr. Walter U. Kennedy, the president, during the state meeting, but many doctors did not get to hear him. Some of the facts he related deserve repeating. For instance, at the end of the first year approximately 124,000 persons held certificates, or policies . . . a phenomenal number for such a short period. Up to the end of last September, 5,325 persons had drawn benefits in the amount of $277,718 which, again, is remarkable. The purpose for which the company was organized—to provide prepayment medical care service on a voluntary basis—is being attained. Mutual Medical Insurance is sound financially and paying interest on the certificates of advancement. Already the coverage has been liberalized, and will be extended further as soon as it is financially safe to do so. Due to the ten months' waiting period, maternity care has recently become effective for family certificate holders, and maternity benefits have automatically become an added medical service.

——ISMA——

The Scholarship Program. Four medical school students and eight girls entering nursing training are receiving financial assistance through scholarships established by the council of our association earlier this year. After their internships the young men must practice in a community where a doctor is needed for a period of five years or else pay back the money. The funds given the nursing school students are outright grants. Recipients of these scholarships have expressed genuine appreciation for the help they are receiving. In Kentucky, in contrast to what we are doing, $153,000 has been raised for use in making loans to medical school students. Seventeen students, one of whom is a woman and one a Negro, are being helped. The Kentucky State Medical Association put $5,000 into the fund, but the other money was donated through a state-wide campaign, the Kentucky Woman's Auxiliary assisting in conducting it. Kentucky medicine is loaning the money only to students who will practice in small communities after they get their medical education.

——ISMA——

This and That. After practicing medicine for sixty years, Dr. W. D. Harvey of Burney, is preparing to retire. He was 91 years old last December 3 . . . Secretary of State Tom Bath, who is offering Indiana physicians 1948 auto license plates bearing the letters "M.D.," has set aside "M.D. 1" for his fellow townsman, Dr. Roscoe L. Sensenich of South Bend, president-elect of the American Medical Association.

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Deaths

Walter C. Engle, M.D., of Indianapolis, died on August sixteenth, at the age of seventy-seven years. He graduated from the Medical College of Indiana, in Indianapolis, in 1897 and had practiced medicine in Indianapolis for forty years.

Judson P. Boulware, M.D., of Bloomington, died on October first, at his home, at the age of fifty-seven years. Doctor Boulware graduated from the University of Pennsylvania School of Medicine, in Philadelphia, in 1916. During World War I he had charge of a base hospital in England, and at the time of separation had attained the rank of captain. Doctor Boulware retired in 1946. He was a member of the Owen-Monroe County Medical Society, the Indiana State Medical Association, a Fellow of the American College of Surgeons, and a Fellow of the American Medical Association.

Thomas J. McKean, M.D., of Montpelier, died on September fifteenth, at the age of seventy-four years. Dr. McKean graduated from the Medical College of Indiana, in Indianapolis in 1905. He was a veteran of World War I, having held the rank of captain in the Medical Corps. Dr. McKean was a member of the Adams County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Joseph P. Wilson, M.D., of Scottsburg, died on September twenty-third, at his home. He was eighty-two years of age. Doctor Wilson graduated from the Kentucky University Medical Department, in Louisville, in 1905, and for over forty years had practiced in the community of Scottsburg.

Walter W. Heald, M.D., of West Lebanon, died on August eighteenth at his home, after an illness of several years. He was sixty-three years of age. Dr. Heald graduated from the University of Louisville School of Medicine in 1911. He was a member of the Fountain-Warren County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Harrison K. Walterhouse, M.D., of Ladoga, died September seventh, at his home following injuries sustained in an automobile accident. Dr. Walterhouse was sixty-eight years of age. He was graduated from the Medical College of Indiana, in Indianapolis, in 1904, and for more than forty years had been a practicing physician in Ladoga. Dr. Walterhouse was a member of the Montgomery County Medical Society, the Indiana State Medical Association, and the American Medical Association.

BURIAL OF SERVICE MEN

Rules relative to the reburial of service men who died and were buried in foreign countries and whose bodies are being returned to Indiana for burial were issued recently to Indiana health officers by the Indiana State Board of Health.

The county health officer must issue a burial permit before an interment is made. When the remains arrive at destination, the funeral director, or person acting as such, shall give to the health officer having jurisdiction the number attached to the outer box, together with the name, rank and serial number which is stenciled on the end of the outer shipping case.

The burial permit shall be issued on standard form V. S. 4 and shall contain the full name, rank and serial number of the deceased, according to the instructions issued to the health officers. The place of death is to be marked as "Foreign" and the cause of death is to be written as "World War II, deceased," giving the name and location of the cemetery, or burial grounds where the body is to be buried.

Any papers attached to the box may be delivered to the family of the deceased. However, it is necessary for the health officer to keep the stub of the burial permit.

ETHICS



There can be no middle course between the ethics of the medical profession ond the temptations of the morket place in the field of anatomical supports. Here the standards of the businessman must be elevated to the standards of the doctor because the customer of the businessman is the potient of the doctor. Anything else is "merchandising quackery." We at Camp have for many decades controlled our distribution throughout the recognized retail institutions which like the doctor have earned the respect and confidence of their home communities. No appeal is used in our advertising approach to the consumer which foils to meet the precepts of the profession. We serve the physicion and surgeon by living up to our chosen function of supplying scientific supports of the finest quality in full variety at prices based on intrinsic value. We try to insure the precise filling of prescriptions through the regular education and training of fitters. In cooperation with medicol and educational public heolth authorities we play the role our resources permit in promoting better posture and body mechanics. That is our idea of the proctical ethical standards which permit the businessman to solicit the recommendotion of the doctor.

Camp Anatomical Supports have met the exacting test of the profession for four decades. Prescribed and recommended in many types for prenatal, postnatal, postoperative, pendulous abdomen, visceroptosis, nephroptosis, hernia, orthopedic and other conditions. If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons", it will be sent upon request.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

September 21, 1947.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Floyd T. Romberger, M.D.; Cleon A. Nafe, M.D.; Alfred Ellison, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; and Ray E. Smith, executive secretary.

Guests: Carl D. Martz, M.D., Medical Consultant to the Division of Services for Crippled Children, State Department of Public Welfare, and Carl F. King, Administrative Assistant, Division of Services for Crippled Children, State Department of Public Welfare.

Membership Report

Number of members September 20, 1947 3,562*
Number of members September 20, 1946 3,429
Gain over last year 133
Number of members December 31, 1946 3,509
* Includes 119 in military service (gratis)
172 honorary members

Treasurer's Office

Instructional Courses. On motion of Drs. Ellison and Romberger the committee is to recommend to the Council that a budget be set up for the Instructional Course Committee and its expenses in the future be handled in the same manner as those of other committees.

Statements of receipts and expenditures for July and August for the Association committees and THE JOURNAL were approved.

1947 Annual Session, French Lick, October 28, 29, 30, 1947

Annual Dinner

a. Guests sitting at the speakers' table are to dress formally. Dress for others is optional.

b. Tables are to be reserved for the ex-presidents and their wives, the councilors and their wives, the Auxiliary officers and their husbands, and the wives of those seated at the speakers' table. On motion of Drs. Nafe and Romberger, Dr. Charles N. Combs is to be asked to take charge of these arrangements.

c. A table is to be reserved for the members of the Fifty-year Club and their wives.

1948 Annual Session

On motion of Drs. Ellison and Romberger, the committee is to recommend to the Council that the 1948 annual session be held the week of October 25.

Legislative Matters

National

Appointment of Oscar R. Ewing, ex-Hoosier, as new administrator of the Federal Security Administration was announced.

Copy of a letter which Governor Gates sent to Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, was reviewed by the executive secretary.

Letter from Louisiana State Medical Society explaining why it had requested the Indiana State Medical Association to join in protesting the appointment of A. W. Dent to the Federal Hospital Council was read. On motion of Drs. Ellison and Nafe the committee voted against writing any protest.

Local

Survey of physically handicapped children. The medical consultant to the Division of Services for Crippled Children, Indiana Department of Public Welfare, and the administrative assistant of the Division, explained the method of making a survey of handicapped children in accordance with Chapter 276 of the Acts of 1947. The consultant was requested to prepare an article outlining the purpose of the survey for publication in THE JOURNAL, upon motion of Drs. Nafe and Romberger.

Organization Matters

Fifty-year Club

a. *Questionable members.* On motion of Drs. Nafe and Ellison, seven candidates certified by the county medical societies for this honor, who were graduated from medical school since 1897, are to be denied recognition this year as all recipients of this honor must have graduated in 1897 or earlier.

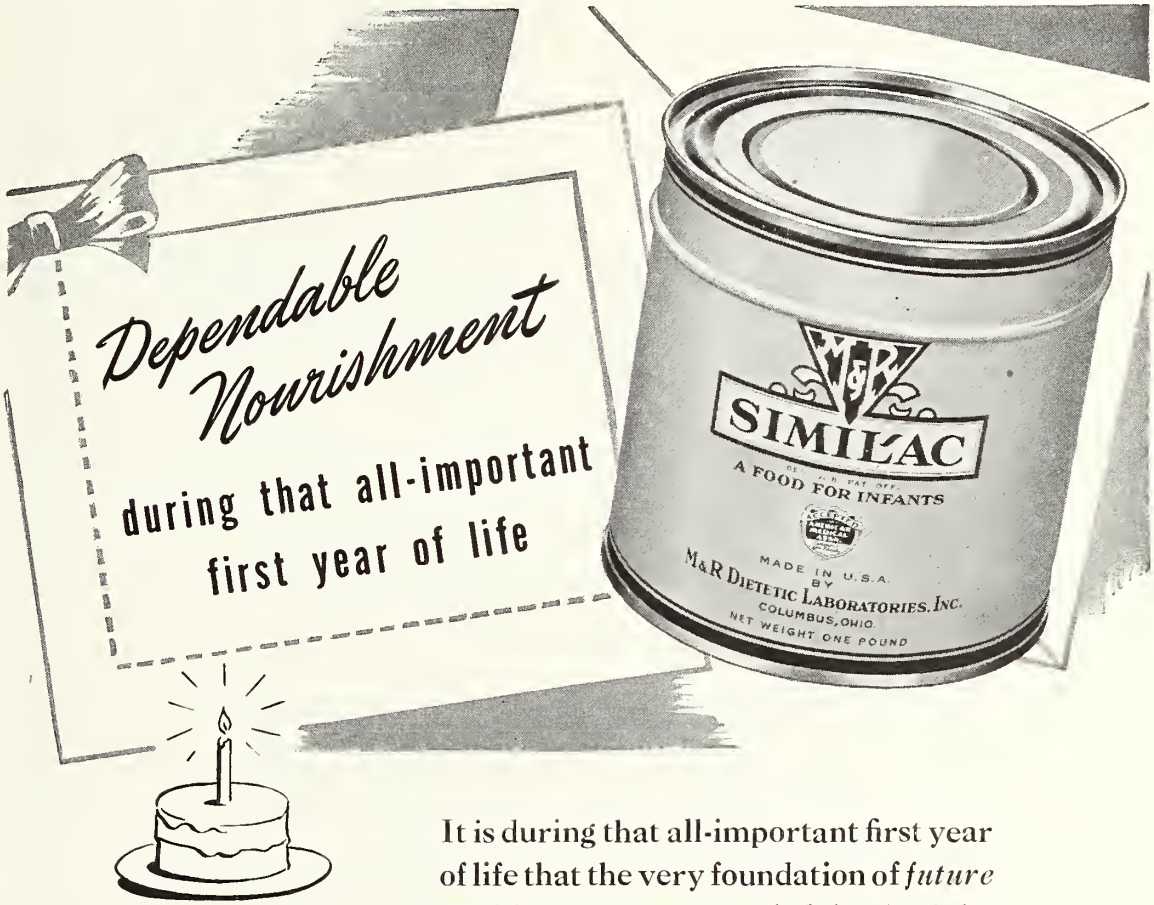
b. *Presentation ceremonies.* On motion of Drs. Romberger and Nafe the names of the recipients of the fifty-year certificates and pins are to be printed and inserted in the annual dinner program. The certificates and pins are to be distributed following the banquet.

Dr. Joseph H. Weinstein of Terre Haute was designated by the president to respond on behalf of the Fifty-year Club members.

Letter received from Governor Gates thanking the committee for complimenting him on the appointment of a physician to the Board of Trustees of Indiana University was read.

Medical publication requests. The executive secretary was directed not to supply information requested by medical publications other than those published under the supervision of the American Medical Association.

Workshop in School and Community Health Education. On motion of Drs. Nafe and Ellison the Indiana State Medical Association is to accept the



It is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. And the well nourished baby is, in most cases, more resistant to the common ills of infancy. Similac-fed infants are notably well nourished; for Similac provides fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle-fed infant—*from birth until weaning.*

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A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

invitation to be one of the sponsors of the 1948 Workshop in School and Community Health Education.

Narcotic prescription law. The following resolution, adopted by the Indiana Pharmaceutical Association, in convention in June, was noted:

"Resolution No. 3

"WHEREAS: The telephone narcotic prescription is illegal in the strict application of the law,

"THEREFORE BE IT RESOLVED: That the Indiana Pharmaceutical Association request the Indiana Medical Association to assist in a program of education of all members of both associations in the necessity of submitting written prescriptions for narcotic drugs and urge a hearty co-operation between the physician and pharmacists in the proper handling of such prescriptions."

Request for mailing list. Permission was given "Outdoor Indiana" to use the association mailing list of members to solicit subscriptions, on motion of Drs. Ellison and Nafe.

Indiana Social Hygiene Association. Notice that an Indiana unit of the American Social Hygiene Association is to be organized in Indiana was read.

Testimonial dinner for president-elect of the A.M.A. Dinner to be held by St. Joseph County Medical Society on October 8 at South Bend.

Nominations for A.M.A. general practice medal. On motion of Drs. Romberger and Nafe the committee voted to submit the name of Dr. Jacob T. Oliphant of Farmersburg for this recognition.

Medical Economics

Complaint regarding excessive medical fee. Letter received from Montgomery County Medical Society explaining that fee charged by anesthetist is the regular charge he makes for this service, brought to the attention of the committee. The chairman of the Executive Committee and secretary were directed to inform the complainant of this fact.

Health and accident insurance coverage. The attorney of the association was directed to prepare an article for THE JOURNAL, calling attention to the wording of insurance policies which is misleading, particularly pertaining to cancellation clauses.

Future Medical Meetings

September 29 to October 2, 1947 — Kentucky State Medical Association annual session, Louisville. The executive secretary is to attend this meeting.

October 16, 17, 18, 1947—Conference on School Health and Physical Education, Highland Park, Illinois. The executive secretary is to attend this meeting.

November 6, 1947—Conference on Home Town Medical Care Program. On motion of Drs. Nafe and Romberger, Dr. Charles F. Thompson, chairman of the Veterans Committee, is to attend this meeting, which is to be held in Chicago.

November 7 and 8, 1947—Conference of State Medical Society Secretaries and Editors, Chicago. On motion of Drs. Nafe and Romberger, the executive secretary is to attend this meeting.

Veterans Affairs

On motion of Drs. Romberger and Ellison the chairman of the Veterans Committee was authorized to sign a new agreement with the Veterans Administration covering home town care of veterans, the dates of the agreement being August 1, 1947, to July 31, 1948.

The chairman of the Veterans Committee reported that his committee had been informed of the discharge of one of the fee-designated examiners and that the committee had accepted the action of the Veterans Administration in this matter. On motion of Drs. Romberger and Nafe the Executive Committee concurred in the action of the Veterans Committee.

The Journal

Report on advertising:

Additions	$ 679.36
Decreases	225.50
Total increase in August and Sept.	$ 453.86
Total increase for year	$1,328.81

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

September 12, 1947.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

Copy for the following "Hints on Health" releases were approved:

Week of October 6, 1947—"Give Doctor All Facts."

Week of October 13, 1947—"Cataracts."

Week of October 20, 1947—"Kidney Stones."

News release about Woman's Auxiliary radio program over WFBM, Indianapolis, for Monday, September 15, 1947, for Indianapolis daily papers, was approved.

Because of the high cost, the bureau decided against making recordings of the Woman's Auxiliary radio programs for use over other Indiana radio stations.

The attorney for the association was chosen to fill a speaking engagement on "State Medicine" before the Greensburg Rotary Club on November 17, 1947.

Letter from L. G. Zerfas, M.D., of Merom, regarding negatives of past president's pictures was read.

Request of Medical Economics for material for an article was approved, and the request forwarded to the Executive Committee for final action.

Editorial against socialized medicine in recent issue of The Van Buren News-Eagle was noted.

"don't smoke"...

IS ADVICE HARD FOR PATIENTS TO SWALLOW!

May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

BUREAU OF PUBLICITY

September 26, 1947

Present: H. G. Hamer, M. D., chairman, and Ray E. Smith, executive secretary.

The following "Hints on Health" releases were approved:

Week of October 27, 1947—"Proper Diet."

Week of November 3, 1947—"The Coronary Arteries."

Week of November 10, 1947—"Brushing the Teeth."

The following news releases about the annual session were approved:

October 2, 1947—"Scientific Topics Feature Medical Meeting Program."

October 7, 1947—"Noted Scientists Will Lecture at Medical Meeting."

October 13, 1947—"Hoosier Doctors Will Honor Next A. M. A. President."

A news release entitled, "Physicians Award Scholarships to Nursing Students," issued by the Committee on Medical and Nursing School Scholarships, was approved.

Policy of the Illinois State Medical Society in employing advertising agency to prepare and release news story about some article in its journal was noted.

Report that news announcer for an Indianapolis radio station had criticised unnecessary operations and hospitalization of the sick September 15, 1947, was discussed and decision reached that he was commenting on paper read before the American College of Surgeons and bureau could not do anything about it.

The secretary reported that offer to supply health literature to classes at Shortridge High School had been made at conference with the principal September 23, 1947.

COUNCILOR DISTRICT MEETING

ELEVENTH DISTRICT

Dr. Edgar F. Kiser of Indianapolis reviewed the history of medicine in addressing the Eleventh Indiana Councilor District Medical Association dinner meeting at the Mississinewa Country Club near Peru Wednesday night, September 17.

In view of the fact that Drs. Frank M. Lynn, David C. Ridenour, and John E. Yarling, all of Miami county, and who have practiced medicine for fifty years or more, were honor guests, Doctor Kiser ably stressed the developments of medicine through the period they have been in practice. Each honor guest was presented with a scroll and a basket of flowers.

Ray E. Smith, executive secretary of the Indiana State Medical Association, spoke briefly.

Entertainment was provided by the Foster Hall Quartet of Indianapolis.

An excellent scientific program was presented in the afternoon. Speakers and their subjects were "Brucellosis," by Dr. Dan L. Urschel of Mentone, and "The Acute Abdomen," by Dr. Philip Thorek of Chicago. Dr. S. D. Malouf of Peru, district president, welcomed the guests.

The program committee was composed of Drs. C. R. Herd, chairman; Doctor Malouf; R. E. Barnett; and H. E. Rendel.

A committee composed of Mrs. H. E. Line, chairman, and Miss Helen Barnett, and wives of the members of the Miami County Medical Society, was host to the ladies in the afternoon.

The next district meeting will be held in Wabash on Wednesday, May 19, 1948.

LOCAL SOCIETY REPORTS

Fort Wayne (Allen County) Medical Society members met on September second at the Chamber of Commerce Building, in Fort Wayne. The speaker for this meeting was Dr. David A. Boyd, Jr., of Indianapolis, whose subject was "Psychosomatic Medicine." Seventy-five members attended the meeting.

Madison County Medical Society members met at the Anderson Country Club, in Anderson, on September seventeenth. Dr. Carl Habich and Dr. A. F. Weyerbacher, both of Indianapolis, discussed "Infertility in Male and Female." More than fifty physicians and guests were in attendance.

Montgomery County Medical Society members held a dinner meeting on September sixteenth at the Crawford Hotel, in Crawfordsville. The guest speaker was Dr. Robert M. Vandivier, of Indianapolis, whose subject was "Management of Diabetes." Nineteen members attended the meeting.

Vanderburgh County Medical Society members were addressed by Dr. Charles A. R. Connor of New York, medical director of the American Heart Association in Evansville, at a dinner meeting Tuesday, October fourteenth. Dr. Connor spoke on "Diagnosis and Management of Rheumatic Fever and Rheumatic Heart Disease." Dr. J. D. McDonald, vice-president of the society, introduced the speaker. The meeting was attended by more than eighty members of the society.



"Beginner's luck" isn't always good

The good luck so often attributed to beginners can't be counted on in infancy. Here the "beginners" often meet insurmountable obstacles which have raised the proportion of infant deaths within the first 30 days to 62.1% of the total infant mortality.* During this hazardous first month proper selection of the first formula is therefore of vital importance.

'Dexin' has proved an excellent "first carbohydrate" because of its high dextrin content. It (1) resists fermentation by the usual intestinal organisms; (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds. 'Dexin' *does* make a difference.

*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

'Dexin' HIGH DEXTRIN CARBOHYDRATE

BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
'Dexin' Reg. Trademark

Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. A. W. Ratcliffe, Evansville.

President-elect—Mrs. William Morrison, Kokomo.

Corresponding Secretary—Mrs. J. W. MacDonald, Evansville.

Recording Secretary—Mrs. Truman Caylor, Bluffton.

Treasurer—Mrs. Wendell Kelly, Anderson.

Press and Publicity—Mrs. F. M. Gastineau, Indianapolis.

OUR GOAL

"Every Physician's Wife An Auxiliary Member"

President's Letter:

Convention is over and we must turn our thoughts to more serious things. Mrs. Gastineau will tell you all about the convention in the December JOURNAL. This month we turn this column over to Mrs. C. O. Richey, *Hygeia* chairman. She is interested in seeing that Hoosier doctors' wives obtain more *Hygeia* subscriptions than ever before. LET'S BRING FIRST PRIZE TO INDIANA.

REBECCA RATCLIFFE, *President.*

HYGEIA CONTEST—Mrs. C. O. Richey, 400 S. Kelsay Ave., Evansville. The twelfth annual auxiliary *HYGEIA* contest is now in full swing. Cash prizes are given to auxiliaries over the country who secure the largest number of subscription credits to the magazine. State recognition will be given to all Indiana county auxiliaries at the House of Delegates in April. Work toward putting your county auxiliary at the top of the state list.

HYGEIA CONTEST RULES

QUOTA: Prizes are based on your group quota and the number of subscription credits obtained. Your quota is the number of members in your auxiliary who have paid membership dues at the close of your previous year. This arrangement gives the auxiliary with a small membership an equal chance with larger ones in their group.

CREDITS: A one-year subscription will count as one credit; a two-year subscription as two credits; a three-year subscription as three credits. No distinction in credits is made in regard to new or renewal orders. Unpaid subscriptions will not be counted in the contest unless payment is received before January 31, 1948.

RESTRICTIONS: No county will be given a cash prize nor special recognition unless its auxiliary has secured at least twenty-five subscription credits. No county or state auxiliary will be given a cash prize unless it has reached its quota (Indiana quota—1,300 credits). No county auxiliary will be given credit for subscriptions taken from members at large of other county auxiliaries.

TIME LIMIT: The time of the contest covers the period from September 1, 1947, to January 31, 1948. All orders in envelopes postmarked on and previous to January 31, 1948, will be counted in the contest. Mail in contest orders to *HYGEIA* Department, 535 N. Dearborn Street, Chicago 10, Illinois. Use order blanks wherever possible.

RATES:

	Rate	Comm.	Send
One year subscription	$2.50	$1.25	$1.25
Two-year subscription	4.00	1.50	2.50
Three-year subscription	6.00	2.25	3.75

SPECIAL RATE FOR PHYSICIANS AND DENTISTS:

A reduction of 50 per cent is allowed for physicians and dentists and their families. These will apply to gift subscriptions also. No commission is allowed on these orders, but credit will be given to your auxiliary.

SUGGESTIONS FROM *HYGEIA* CHAIRMAN:

1. Be sure every physician and dentist in your community gives the medical auxiliary credit on new or renewed subscriptions by writing on the subscription blank, "Credit to————auxiliary."
2. See that *HYGEIA* is in all your schools. Ask them to give you contest credit on renewals.
3. Check the libraries and also ask them to give you credit.
4. Contact your friends. Give them a copy of your *HYGEIA* to read. P.-T. A. study groups and health chairmen should be interested.

MARSHALL COUNTY

The Auxiliary to the Marshall County Medical Society met on Wednesday, October 1, at Coral Gables, in Plymouth for luncheon. Fourteen members and one guest were present. A short business meeting followed the luncheon, in charge of the newly elected officers, as follows: President, Mrs. F. D. Hogle; Vice-President, Mrs. R. L. Witham; Secretary-Treasurer, Mrs. H. D. Tripp.

Program and finance committees were appointed.

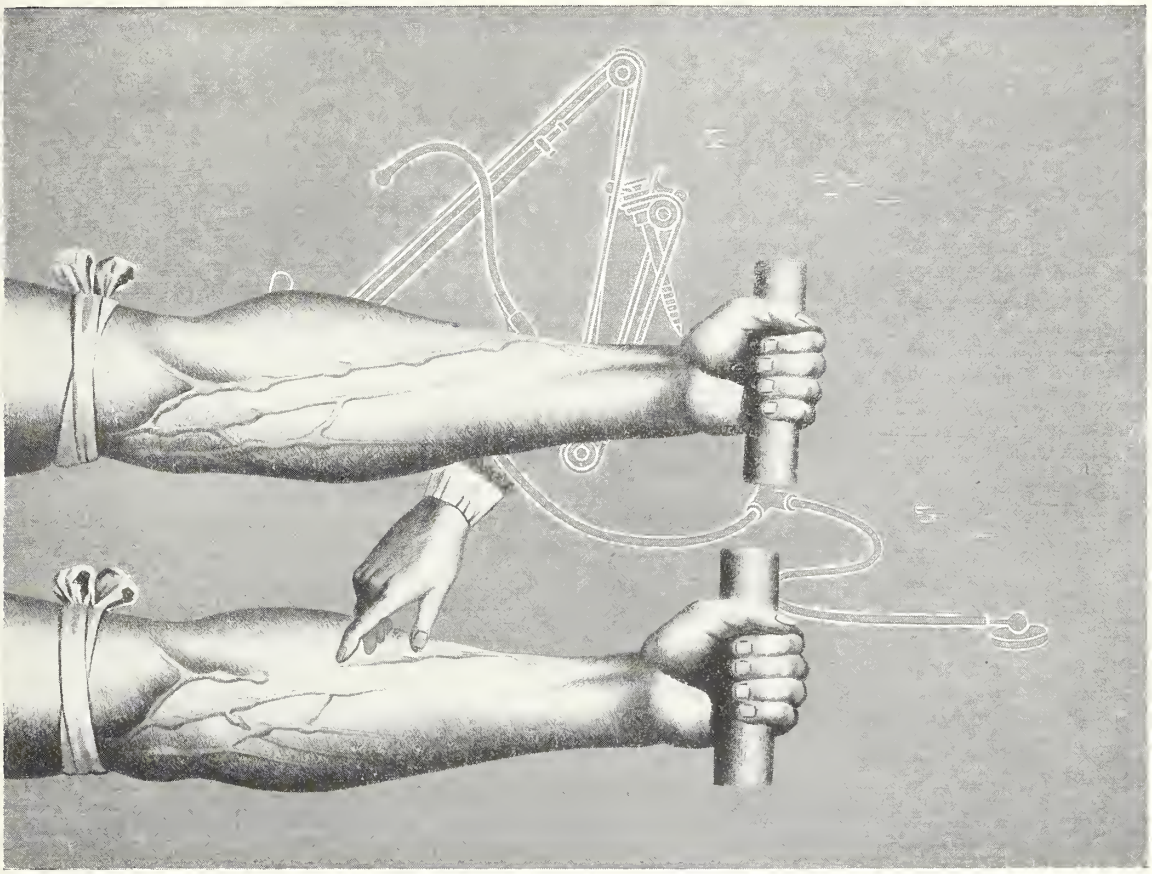
Following the business session the group adjourned to the home of Mrs. Tripp where an interesting social period followed. Mrs. Charles Stewart gave an interesting demonstration on hat making. The afternoon was concluded with bridge.

MRS. H. D. TRIPP, *Sec.-Treas.*

VANDERBURGH COUNTY

The Women's Auxiliary to the Vanderburgh County Medical Society will meet for luncheon at the McCurdy Hotel, November 11, 1947.

The presidents and representatives of various organizations interested in health problems will be invited to meet the wife of the new Executive Secrtary, Mrs. Arthur P. Tiernan.



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THE PARADOX OF PSYCHONEUROTIC MALINGERING*

ALEXANDER R. MACLEAN, M.D.†

ROCHESTER, MINNESOTA

As a representative of a vanishing medical species I am greatly honored to have this opportunity of addressing you. Like the eclectic school of medicine, clinical neurology is disappearing from the continent of North America. We neurologists were born of internal medicine, together with a twin named "psychiatry." For several decades we stole the milk, grew fat, and prospered. We left internal medicine, assumed the independent title of "specialist" and, dragging our twin by the hand, we sauntered over the world. The twin grew and we stopped growing. The twin, psychiatry, grew into a giant, doubtless because of certain glandular disturbances. Now we neurologists stumble on behind our twin. We are too weak to feed ourselves outside of big institutions. In private practice the neurosurgeon snatches our daily bread, and the only way we can exist is to follow in the footsteps of our big brother and practice psychiatry. And yet we are the link between medicine and psychiatry. We are the printed or unprinted hyphen in the word "psychosomatic," and I think that we have some insight into both the failings of the body and the failings of the mind. Medicine is old enough and mature enough to criticize itself. Psychiatry, in its youth, has not learned the immense value of this critical introspection. As a neurologist I propose to introduce some aspects of my twin activities which continue to puzzle me.

On my part, the dilemma began while I was in the naval service, on an island called Attu. We named it, then, the "Aleutian problem," but I have since learned that it was common to all theaters of war, that it had existed before the conflict, and that it dwells among us now. I have therefore called it the "Paradox of psychoneurotic malingering." In brief, the problem is as follows.

The disease, psychoneurosis, is in essence an illness of the personality, frequently expressed in terms of bodily complaints. It represents an unconscious transfer, by the patient, of a psychic difficulty to a somatic one. We are all familiar with the devastation that results. On the other hand, there is a type of human behavior which is called malingering and is the conscious masquerade of a problem in living under the guise of organic malfunction.

Before the war those of us who were not in the penal, compensation, or insurance practice of medicine rarely considered this second entity in our differential diagnosis. And yet in the army and navy, perhaps because of our own temptations, we were constantly aware of the possibility that a transference of mental unhappiness to a physical disability might be conscious and deliberate. We asked ourselves the following question many times a day: Is this patient's functional illness valid, or is it fraud? Now that war is over I find myself continuing to ask this question because I have no certain landmarks in the fields of medicine or psychiatry to guide my decisions.

Any opinion that a patient's disorder is either a conscious or an unconscious attempt to remedy an unpleasant situation cannot be formed on the basis of any tests with which I am familiar. Psychoneurosis and malingering shade into one another so imperceptibly that no sharp dividing line can be established. A middle zone composed of psychoneurotic patients, consciously exaggerating

* Presented at the General Meeting of the Indiana State Medical Association at the annual meeting in French Lick, October 30, 1947.

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their disorder, and malingering culprits with an unstable nervous system is so broad and confused as to render absolute decisions judicially impossible. The problem remains so unsettled that it is given scant consideration in authoritative psychiatric literature. Again and again one reads medical articles describing tests devised to trap a patient into demonstrationg that he can see from a blind eye or can detect sound through a deaf ear. The authors have not appreciated the proved psychological truth that the hysterically blind, although unconscious of the fact, can and do physically see and that the hysterically deaf can and do physically hear. These tests, although they demonstrate either conscious malingering or unconscious hysteria, cannot in any way distinguish them.

Inexact concepts have further distorted the problem of "neurosis versus malingering," by arbitrary divisions between the two based upon the goals sought by the patient. If a person seeks an intangible goal or an unusual one, such as the escape from normal sexual experience, by adopting functional disability, the full weight of society, medicine, and psychiatry is thrown to the side of neurosis. On the other hand, if the same person should gain a tangible and particularly a monetary reward from functional disability, such as escape from punishment, or the collection of insurance money, psychiatry straddles the fence between psychoneurosis and malingering, and the great body of medicine and society in general term such behavior "fraud."

With this cloudy conception of functional disability most of us went to war, either with naive beliefs that our instinct could pick and choose between malingering and psychoneurosis, or with biased opinions that everything that was not organic was "faked," or that everything that was not organic was the result of an irresponsible mental illness. What happened could be expected. The incidence of functional disability in our armed forces overwhelmed the psychiatric personnel. Those of us who had to deal as best we could with this crippling, intangible entity which filled our hospitals learned by trial and error certain facts which must have some application to the civil practice of medicine.

The goals sought by our patients were colored by military existence in different portions of the world. Our islands, stretching thousands of miles into the Bering Sea, through their very nature, weather, and isolation, bred unhappiness and discontent. The psychiatric disabilities which resulted represented conscious or unconscious attempts to escape the area. The possible reward of escape was obvious, tangible, and suspect. We were forced to face at last the paradox of psychoneurotic malingering, and we were forced to recognize the essential defects in our psychiatric philosophy.

When we were asked that constant question which so often arose in a military setting, "Is this man neurotic or malingering?" we answered, "He is one or the other—or both." When we were asked to make decisions in regard to the therapy and disposition of our patients we had no honest certainty that our choice was the correct one for either the patient or the group. However, some experience in the examination of the patient, the psychiatric approach to the patient, and his ultimate disposition allowed us to resolve some of the difficulty in a manner which was practicable and which still appears to be satisfactory. Certain changes took place in the technic of our examination of patients. We were frequently called on to give a neuropsychiatric opinion in regard to a bizarre anesthesia discovered incidentally in the course of clinical examination. More often than not, a stocking and glove anesthesia was apparent. Prior to our naval service, we would have catalogued the patient as hysterical. We learned, however, to lose much respect for the results of a sensory examination conducted in a military atmosphere. Many normal persons, with no previous suggestion of psychoneurotic behavior, frequently presented bizarre sensory pictures. Patients with organic disease were equally susceptible. The time honored neurologic trick of having the patient with his eyes closed say "no" every time he was touched with cotton over an anesthetic area served no function except to demonstrate that the patient's sensory apparatus was intact. It did not prove that hysteria was present and, equally, it did not prove deceit. Similarly, in the course of examination, a functional weakness of an extremity, or pinhole vision, deafness, or blindness would often develop in varying degree. It was found that these civilian stigmata of psychoneurosis hysteria or malingering frequently were not associated with any connotation of emotional instability or fraud. They were often merely indexes that the patient was very suggestible, and that the physician was too enthusiastic and persistent. Indeed, more frequently than not, these abnormalities served to measure not disability but the technic of the examining physician.

In the anxiety states somatic signs are frequently said to give valuable clues as to the state of inner turmoil of a patient. Nervous tachycardia, sweating, dryness of the mouth, labile hypertension, tremor, syncope, hyperventilation, and vomiting, all are products of storms in the autonomic nervous system, storms which cannot be turned on or off by an act of will, and yet these involuntary signs may not be criteria of psychoneurosis. In military service they frequently were not, for certainly the malingerer came before his judge with trepidation and with fear. He was anxious concerning the medical verdict and the punishment which discovery would entail. He, too, might demonstrate external signs of nervousness but these signs were a result of his chosen disability and were not factors related to cause. A man who was not psychoneurotic and who was not malingering could also present the stigma of malfunction of the autonomic nervous system if his examination carried with it consequences of tremendous import.

If the result was to be a decision to send him back to the United States or to retain him overseas, it would be unusual if his heart maintained an unconcerned rhythm. Therefore, these somatic counterparts, previously presumptive of psychoneurosis, could not be depended upon to separate military borderline cases. The clinical picture of psychasthenia, neurasthenia, posttraumatic neurosis, and often psychosis was in a similar manner often colored by admixtures of undue suggestibility, exaggeration, and deceit.

A psychiatric diagnosis is said to represent the cross section of a longitudinal life story of adaptation. Theoretically, the distortions which I have just described would play little part in the judgment of the psychiatrist who knew the facts and details of a lifelong history, but we had no longitudinal perspective. When one could be obtained from relatives, the story they would give was frequently more biased than the one given by the patient. They wanted their boys home; they wanted them out of danger.

There appeared to be no solution to the problem but a solution had to be found. It was not so much the question of the individual resolution of a medical case as it was an area morale problem. If weak men were rewarded for their failure by being sent home, the men remaining tended to lose the incentive to endure.

It was the psychiatric approach to the patient rather than the formal examination that disclosed evidence that was of value in both diagnosis and disposition. Did the patient enlist, or was he unwillingly drafted? Had he seen duties in other theaters of war? Had he been in combat? What was his length of service? The answers to these questions formed the basis of judicial but not purely psychiatric decisions. It was equally true that the service background of the psychiatrist played a very important role in this approach to the individual problem. No psychiatrist in a continental hospital who had not been in our area or in similar areas could truly appreciate the local difficulties of the men and their environment. Patients recognized this unfamiliarity and either deeply resented probing or they distorted the Aleutian scene and exaggerated their efforts to adapt themselves to it. They refused to accept unpalatable truths concerning their behavior, courage, and stamina from men who had not undergone similar difficulties.

Our opinions in regard to therapy and disposition of psychoneurotic patients changed remarkably during overseas duty. For my part, when I arrived in the Aleutian theater of war, I was not unfamiliar with military psychiatry, but although I had spent two years in the wards of an active naval continental hospital, I was not prepared to face the problem which confronted me. I hospitalized many more patients than necessary, and I sent a significant number back to the United States whom I later would have retained in the area. Two, and possibly three considerations changed my attitude.

It soon became apparent that the more men I hospitalized for psychoneurosis and the more I sent home, the more I saw with identical symptoms and findings. I became a focus of a vicious circle, and undoubtedly in some measure I was responsible for it.

I soon realized that the other medical men in the vicinity, although they had no psychiatric training, had solved the psychoneurotic problems of their organizations in a manner that was ultimately more efficient than my own. The medical officers of construction battalions, whose men were in older age groups and potentially more susceptible to difficulties in adaptation, seldom referred patients to me for appraisal. When they did they were usually solely concerned with the problem as to whether the patient was psychotic or suffering from an organic disease of the nervous system. Although they recognized the entity of the psychoneurotic patient, they had learned through experience that such a patient could not be handled by ordinary civilian methods by a "state side" psychiatrist. Their difficulties were accentuated by the fact that most of their men came from industrial settings and were familiar with the intricacies of industrial medicine and the compensation board. These workmen were not novices in the relationship which exists between doctor and patient when monetary values were at stake, and they applied this knowledge persistently in battalion sick bays. The result was that the medical officers were forced to establish a general working rule of thumb that psychoneurosis was not a disabling disease.

The third factor, which is difficult to verbalize, and which is equally difficult to evaluate in oneself, is the callousness which came of the prolonged Aleutian duty. The more a man endures, the more he feels justified in requiring others to attempt.

Whether my resulting change of attitude was valid from a psychiatric point of view or whether it was a brand of heresy, the fact remains that it solved for me the local problem of psychoneurosis versus malingering. I united them as a single entity and I treated them as one disorder. My psychoneurotic patients were suspected of exaggerating their complaints and my malingerers were endowed with the benignity of an unstable nervous system. I listened to the problems of the malingerer with the patience and understanding due a man who was suffering from a disorder not of his own choosing, and I did not hesitate to use therapeutic disciplinary measures on nervous men who had not learned to discipline themselves. Both groups were offered all the aid that the medical department could give them in terms of adjustments of types of duty, discussion of problems with superior officers, reassurance of repeated medical examinations, and a detailed explanation of the essential nature and background of their nervous state. They were

encouraged and treated with sympathy, but it was made very clear to them from the onset that they would stay in the area until their tour of duty was completed. Adjustment to adult life was to be made then and there, and not at some remote place in some distant future. These patients were not hospitalized except for overnight periods when occasion warranted. The door to the United States never swung ajar invitingly and all uncertainty as to its opening was resolved. If, in spite of repeated consultation, encouragement, and adequate discipline, I was told that the patient created more of a morale problem than would result if he were removed from the sector, then, and then only, was he evacuated. Such a policy may seem severe in civilian psychiatric circles, but I am certain that the great majority of our psychoneurotic patients under this benign military discipline functioned effectively far away from the United States. Although they may not have been able to adapt themselves to active combat, they were safely retained in the area in spite of its environmental difficulties and, most important of all, they benefited by it.

I am fully aware that such a program could not be instituted in the United States or in large evacuation centers where there is little intimate contact between the medical officers and their patients; however, the central theme of my argument remains valid. The theoretical difference between psychoneurosis and malingering could neither be properly assessed nor practically applied in the resolution of functional disorders in a military setting. If it could not be done among men under the constant discipline and ever present scrutiny of the service, I doubt that it can ever be done in a medical or psychiatric manner in civilian life. The law frequently demands an answer, and yet, for myself, I can only say of a functional patient, "He is a psychoneurotic, he is a malingerer, or he is both." I have seen the problem solved in a remote land by archaic methods, and I am puzzled as to why we cannot solve it here. Is it possible that we, in our present medical and psychiatric concepts of functional disability, through our methods of approach, our examination, our diagnosis and treatment, are creating vicious circles of disability in our own civilization, or is it our civilization that is at fault?

CORRECTION OF CHRONIC SINUSITIS†

J. Jerome Littell, M.D.*

INDIANAPOLIS

THE correction of chronic sinusitis is a problem which constantly confronts all practitioners of medicine and is placed specifically at the door of the specialist in that field. It is a very common ailment, and as such deserves intelligent consideration and a constructive attitude, rather than a too prevalent hopeless reaction that it is just one of those things which flesh is heir to and must learn to live with.

Sinusitis can usually be corrected, to a degree closely approaching and often attaining a complete cure, by methods which are easily and safely within the reach of the average sufferer. A careful study of the individual case is of course necessary. An evaluation of the various factors of allergy,[1] emotional states, and other bodily functions which contribute to vasomotor disturbances of the nose, with resulting activations of intrinsic inflammatory tendencies, is necessary. It may be that these sensitivities are manageable and correctable to the point of producing permanent inactivity in the affected areas. It is obviously necessary that the medical man be freely consulted and that he be given full opportunity to correct whatever bodily states might have a bearing on the sinus condition. The antibiotics may be tried, but they have proved of little value in eradicating a well-established sinus infection. Like all forms of local treatment they are largely palliative and do not strike at the essence of the trouble, which is either some form of mechanical blockade and/or an irreversible pathologic change in the mucous membrane lining of the sinus.

If the above measures suffice, or the difficulty is of minor importance, well and good, but in a great many cases this is not so. For that reason the permanent solution of the problem often resolves itself into a surgical procedure.

The growing pains of our specialty have produced many types of surgical approach. There are those who hold entirely to ultraconservative methods, while others feel that the most complete types of surgery are desirable.[2] It seems to the writer that either of these attitudes of mind is faulty. The middle ground, with a willingness to adopt either a conservative or more complete surgical approach, or a combination of the two in any given case,

‡ Presented before the Indianapolis Medical Society, June, 1947.

* From the Otorhinolaryngology Department of the Indiana University School of Medicine.

[1] Mullin, W. V.: Surgical Indications, Diseases of Nasal Sinus Due to Allergy, *S. Clinics N. America.* 15:839, Aug. 1935.

[2] Smith, Ferris: Management of Chronic Sinus Disease, *Arch. of Otolaryng.* 19:162, 1934.

Figure I

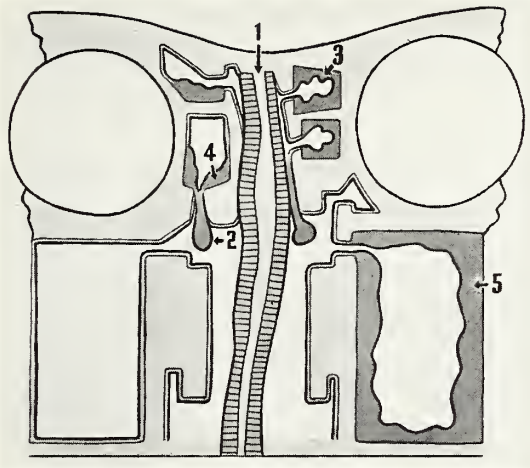


FIGURE 1. High septal deviation with hypertrophy of right middle turbinate. Mechanical defect has produced chronic suppuration with thickening of the sinus membranes in the ethmoids and left maxillary sinus. (1. Septum. 2. Mucopurulent discharge. 3. Posterior ethmoid cell. 4. Anterior ethmoid cell. 5. Hyperplasia of mucous membrane lining of left antrum.)

Figure II

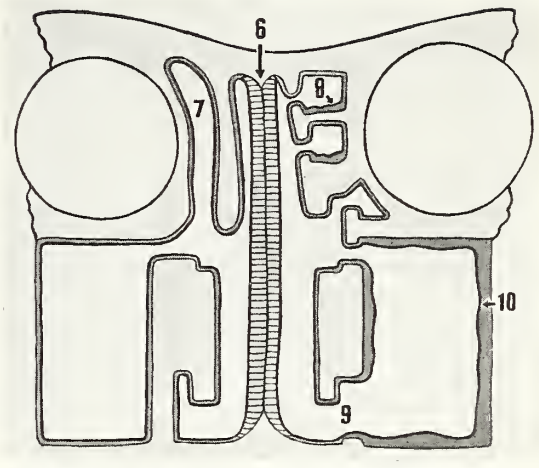


FIGURE 2. A few weeks after intranasal surgical correction. (6. Septum straightened all the way to the roof. 7. Ethmoidectomy performed beneath right middle turbinate. 8. Ventilation is allowing thickened membrane to return to normal. 9. Adequate window in left maxillary sinus which should remain patent. 10. Membrane returning to normal following ventilation from window resection.)

surely recommends itself to one whose chief interest is the management of sinusitis. The surgery, simply stated, should adequately ventilate any area which will recover its healthy state by this means, and totally remove that tissue which has lost its power to become healthy.

It is the writer's custom to approach a case of chronic sinusitis as follows:

A. *History.* In a great majority of cases definite indications will be given which will determine the onset, predisposing causes, allergic components, emotional and other factors. The relationship between the local pathology and systemic complaint can often be established. The symptoms of sinusitis are not constant. Variation in the intensity of the symptoms and often in the location, in the case of head pain, is characteristic. They are usually worse in damp weather—worse in the changeable and colder months, although fatigue and other factors of depleted resistance may operate. Recurrent sore throat in the absence of tonsils or an unexplained cough, a stuffy ear, fatigue, or rheumatic pains in damp weather may guide one to a diagnosis.

B. *Clinical Observations.* These cases must be carefully studied. Willingness to spend time in their observation is essential. The problem in some, of course, is quickly evident, but in others careful repeated observations are necessary. Response to shrinking with a mild shrinking agent (3 per cent cocaine) and noting the tissue color and consistency is most valuable. Free pus is rarely visible in the nose. It has been the author's observation that the cases which do show free secretion in the nasal chambers (excepting acute cases) are the least harmful and often have an allergic component. A tight area in the upper nose, very often in the olfactory fissure, an area which is persistently too red on repeated observation, is productive of trouble.[3] One side of the nose will be more stuffy than the less active side, although the patient may be unaware of it. In the absence of pain, and many do not have it, this silent possible menace to the health of the patient goes its way undiscovered unless searched for. A valuable clue to presence of infection above is the palpation of deep cervical glands, more evident on one side—often tender on deep pressure posterior to the angle of the jaw, accompanied by a feeling of deep resistance to the palpating forefinger or thumb (both sides of the neck palpated at the same time by these two digits of one hand). Reddened thickened bands on the lateral wall of the pharynx, noticeable when the patient is made to gag, and which disappear from view behind the soft palate, are mute testimony to a persistent irritating discharge from that side of the nose and dripping posteriorly over the dome of the palate.

C. *Determination of Sinusitis as a Focus of Systemic Damage.* It is of the greatest importance, after establishing a diagnosis of sinusitis, *to determine what it is doing to the patient.* One is usually able to determine with some confidence whether or not the often latent area is associated with general disease states, an advantage that is less apparent with a focus such as tonsillar or dental infection, because its activity notoriously fluctuates. In the

[3] Littell, J. J. "Disturbances of the Ethmoidal Branches of the Ophthalmic Nerve, etc." *Arch. Oto.* 43:481-499, May, 1946.

author's opinion, the most common of these *morbid states* are generalized fatigue and aching, very often periarticular. *The repeated association between an increase in these symptoms and an increase in the local congestion is most significant.* A decision based on this finding is rarely wrong, as the correction of the local pathology will demonstrate.

D. *Diagnostic Procedures.* In addition to the above, transillumination is used, but not depended upon. X-rays similarly are helpful, but a diagnosis based on them is often faulty, both in a positive and a negative way. Both transillumination and x-ray study should be supported by clinical findings. Maxillary and sphenoid sinuses should be washed out, preferably through the normal osteum.

E. *Allergy Determinations.* It is the author's belief that almost all cases should have intradermal tests for the common allergens. This is simple, quick, and more dependable than eosinophile smears. Elimination diets are tried if foods are suspected. This study saves future embarrassment and allows a more accurate prognosis if surgery is indicated. It often also makes surgery unnecessary.

F. *Surgical Procedures.* Adequate ventilation will cure a large proportion of diseased sinuses. The maxillary and sphenoid are particularly susceptible to this approach, as an adequate window clears up the vast majority of them—even very advanced cases (92 per cent, Hempstead[4]) provided pathology in the upper nose is corrected. A radical operation on these large sinuses is usually unnecessary. These larger cavities lend themselves so well to ventilation because of their size, and air can be made to reach them permanently. This is not true of the ethmoid cells because of their smaller size, and therefore there is a consequent tendency to close if simply opened.

Most of the diseased states for which patients seek help, in the writer's opinion, are due to chronic infection in a tight area in the upper nose. Adequate ventilation here is more difficult to obtain than with the maxillary sinus. In certain cases, where correction of a marked septal deviation will produce 3 mm. of free space here, and the ethmoid pathology is not too marked, simple measures will suffice. But the submucous resection of the septum per se has too often proved a disappointment. Frequently a partial or complete ethmoidectomy is required, with removal of a portion of the middle turbinate body, if necessary, in addition. This must not be done half-heartedly or a poor result must be expected. Pathologic cells within surgical reach much be replaced with a smooth, clean cavity, denuded of membrane with no chance for infected pockets to become walled off with granulation and synechiae. This operation must be immaculately done but is safe, simple and productive of more brilliant results than any procedure in the author's hands. This view is supported by Faulkner[5] and others. The improvement is gratifying and permanent. Properly performed, it replaces in the vast majority of cases the more extensive external operation. It is usually simple to do all the procedures necessary in a case at one time; *and it is important to correct all of the things that are faulty—not just some of them.* The patient must not be asked or forced to return for further attention and treatment or other operations. Such a result can usually be attained. Surgery of the more complete type is reserved for these rare cases which obviously have not and will not respond to the above measures. On the percentage basis these are uncommon.

Conclusions

1. Chronic sinusitis can almost without exception be permanently corrected to a highly satisfactory degree.

2. Careful evaluation of predisposing factors is necessary, particularly with reference to allergies. Intradermals of the common allergens are made where indicated. This is easily performed, and more certain than placing dependency on eosinophile smears. Elimination diets are recommended if foods are suspected.

3. In cases not cleared up by simple means, surgery can be depended upon to produce an eminently satisfactory result. One is not justified in applying so-called conservative or complete approaches to all cases. The choice of operation should be determined by the pathology, but should be adequate, with surgical correction of all pathologic areas, not just some of them.

4. Simple adequate ventilation of the large sinuses is usually curative if the upper nose is made healthy.

5. It is axiomatic that the upper nose must be mechanically good to allow adequate ventilation of the olfactory fissure.

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[5] Faulkner, E. R.: End Results of Operations on the Ethmoids, *Arch. of Oto.*, 30:716, Nov. '39.

ACUTE ISCHEMIC NECROSIS OF THE ANTERIOR COMPARTMENT MUSCLES OF THE LEG

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ISCHEMIC necrosis of the anterior compartment muscles of the leg is a comparatively rare condition. Clinically it is characterized by a sudden onset of pain, swelling, and redness over the anterior portion of the leg, followed sometimes by necrosis and paralysis of the anterior compartment muscles. It may simulate peritendinitis crepitans, cellulitis, periarteritis nodosa, Buerger's disease, tibial periostitis, or fibrositis. Horn[1] described two cases occurring in young, healthy soldiers following prolonged marches, with no history of direct trauma to the area involved.

The following case is an example which occurred in an otherwise healthy, young male with no history of previous direct trauma, prolonged marching, or exhaustive exercise:

A white male, R. A. B., 25 years old, a truck driver, was admitted to the hospital complaining of pain and redness over the anterior part of his left leg. Two days prior to admission a small, fluctuant area the size of a marble appeared on the anterior surface of the left leg, one inch lateral to the mid-shaft of the tibia. He began to have cramps in this area upon walking. Five hours later the cramps became severe and his leg began to swell on the anterior portion, and redness appeared. He received bed rest, elevation of the leg, and 180,000 units of penicillin intramuscularly prior to admission to the hospital.

Both past history and family history were essentially negative, except that he smoked one package of cigarettes daily.

Physical examination on admission to the hospital revealed a well-developed, well-nourished young male complaining of pain in the left leg. There was tense swelling and redness over the anterior compartment of the left leg at the mid-portion, covering an area 14x8 cm. No fluctuation was present and the tibial shaft was slightly tender to pressure. Palpation over the involved area and dorsiflexion of the left foot caused severe pain. The left inguinal lymph nodes were moderately enlarged and slightly tender. A diminished dorsalis pedis pulsation was felt on the left. Laboratory studies were normal except for a 10,600 white blood count with 73 per cent segmental cells. X-ray of the left tibia was normal. A temporary diagnosis of acute tibial periostitis was made, and the patient placed on penicillin and bed rest therapy. During the next three weeks he received 11.5 million units of penicillin via the intramuscular route. Thirteen days following admission the redness, swelling, and pain subsided. At that time he noticed that he was not able to extend any of his toes, nor could he dorsiflex his foot at the ankle joint, but was able only to invert his foot slightly (Fig. 1). Repeated x-rays and laboratory studies were normal. He had no fever following admission, and no chills. Fluctuancy did not appear, and no gross evidence of muscle atrophy could be determined by clinical examination.

He was discharged from the hospital five weeks following admission, and placed under observation. By this time he had lost all power of toe extension and dorsiflexion of the left foot. He was able to invert his left foot slightly, mostly by the action of the Tibialis posterior muscle. After his discharge from the hospital he received two months of active physical therapy, but the muscle paralysis did not improve.

The patient was readmitted to the hospital three and one-half months following his first admission. Physical examination had not materially changed

Figure 1

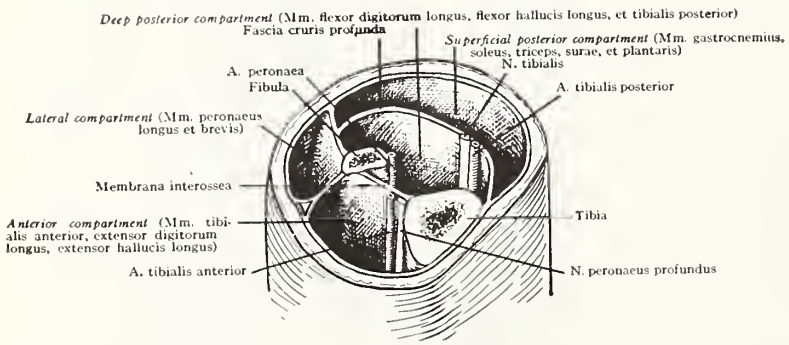


[1] Horn, Carl E.: Acute ischemia of the anterior tibial muscle and the long extensor muscles of the toes. *J. Bone and Joint Surg.*, 27:615-622, Oct. 1945.

except for a one inch atrophy of the leg muscles at the calf level on the left, and the left dorsalis pedis pulsation was questionable. Five weeks later a vertical incision was made over the anterior compartment of the left leg, and the Extensor digitorum longus, Tibialis anterior, Extensor hallucis longus muscles were found to be of a necrotic nature resembling the "crush syndrome."[2,3,4,5,6] The deep peroneal nerve was intact, but the anterior Tibial artery was fibrotic and its patency questionable. A debridement of the affected muscles and sheaths was performed. The pathological diagnosis of the tissue removed was "ischemic necrosis of muscle tissue." Culture showed Staphylococcus aureus. The wound sloughed necrotic tissue and showed no signs of healing. Three months following his operation another debridement was performed, and a third debridement followed the second by one month. The wound healed after the third operation, and the patient was fitted with a walking brace, and thus his foot drop was prevented.

The anterior compartment of the leg is bounded in front by the deep fascia, laterally by the anterior intermuscular septum, posteriorly by the interosseus membrane and anterior surface of the fibula, and medially by the lateral surface of the tibia (Fig. 2). It contains the Tibialis anterior, Extensor digitorum longus, Extensor hallucis longus, and Peroneus muscles. It also contains the deep Peroneal nerve, and the anterior Tibial artery.

Figure II



The Tibialis anterior muscle inserts into the medial and under-surface of the first cuneiform bone and the base of the first metatarsal bone. The Peroneus tertius muscle inserts into the dorsal surface of the base of the fifth metatarsal bone. Both are direct flexors of the foot at the ankle joint (Fig. 3).

The Extensor digitorum longus muscle inserts into the second and third phalanges of the second, third, fourth, and fifth toes, and extends them.

The Extensor hallucis longus muscle inserts into the base of the distal phalanx of the first toe, and gives the power of extension.

The deep Peroneal nerve originates from the common Peroneal nerve at the level of the neck of the fibula, and accompanies the anterior Tibial artery downward through the anterior compart-

Figure III



[2] Robertson, H. R. and Mathews, W. H.: Crush syndrome. *Canadian M. J.*, 46:116-120, Feb. 1942.

[3] Bywaters, e g l: Crushing injury. *Brit. M. F.*, 2:643, Nov. 28, 1942.

[4] Duncan, George W. and Blalock, Alfred: The uniform production of experimental shock by crush injury: possible relationship to clinical crush syndrome. *Ann. Surg.*, 115:684-697, Apr. 1942.

[5] Patey, David H. and Robertson, J. Douglas: Compression treatment of crush injuries of the limbs. *Lancet*, 1:780-782, June 21, 1941.

[6] Bywaters, e g l: Ischemic muscle necrosis. *J.A.M.A.* 124:1103-1109, Apr. 15, 1944.

ment. It supplies the four muscles within the compartment.

The anterior Tibial artery arises from the Popliteal artery at the lower border of the Popliteus muscle and enters the anterior compartment through the upper part of the interosseus membrane. In front of the ankle joint it proceeds downward as the Dorsalis pedis artery.

The deep fascia, fascia cruris, completely inverts the anterior compartment muscles, and is continuous with the fascia lata of the thigh above. It is quite thick and strong in the upper and anterior part of the leg, however is thinner posteriorly, covering the Soleus and Gastrocnemius muscles.

The pathological picture appears to be one of muscle degeneration and arterial spasm, followed by an arterial fibrosis, with a subsequent partial or total occlusion of the lumen. The muscle changes are not very different from those seen in cases of Volkmann's ischemic contracture. Horton[7] points out that it is important to understand the difference between vasospasm and normal vasoconstriction. Vasospasm is the spasm in the vessels which is added to the normal degree of vasoconstriction present in all blood vessels. Of course, the degree of vasoconstriction is variant in different parts of the body, the hands and feet being amply supplied. Montgomery and Ireland[8] found that vascular obstruction was confined for the most part to the large arteries of the extremities.

The term "peripheral vascular disease" indicates a decrease in the normal amount of blood to a peripheral part of the body. Ochsner and DeBakey[9] concluded that this decrease was usually due to a diminished intraluminal volume of the peripheral vessels, and might be caused by two factors, namely, obliterative structural change in the vessels, and abnormal vessel spasticity. The latter condition in many instances can be favorably treated by appropriate therapy. Bywaters[10] stated that during the 1940 air blitz in London the surgeons had many cases of the "crush syndrome" of the extremities, due to direct trauma. In some instances the surgeons, concluding that the swelling of the muscle in the deep fascial compartment was compressing the artery, made incisions along the course of the artery. Large quantities of serous fluid seeped from the wounds, and pale necrotic muscle bulged out. After this procedure, in some of the cases a distal pulse was restored. It seems possible that arterial spasm by itself, without the increased tension in the subfascial tissue, may oftentimes be sufficient to cause peripheral ischemia, especially when hemorrhage into the arterial sheath occurs. In some cases a resultant ischemia might contribute to the development of gas bacillus infection.[11]

The above patient was a truck driver who stated that he had not been working hard, nor had he been working long hours at a time. There was no history of direct trauma to his leg. Some men believe the arterial fibrosis might be due to overwhelming demands on the anterior tibial artery following exhaustive exercise. This does not appear to be so in the above case, since he gave no such history. The anterior compartment walls of the leg are quite rigid, and do not allow for much swelling within the compartment. This factor in itself exposes the contents of the compartments to circulatory disturbances.

The treatment in mild cases, in which pain is the only symptom, with no redness and with no visible swelling, should consist of bed rest and elevation of the affected extremity. In those cases in which there is pain, accompanied by slight swelling and mild redness, repeated lumbar sympathetic blocks every other day are advocated, along with bed rest and elevation of the extremity. In the acute, fulminating cases, as above, a vertical incision over the anterior compartment should be made at the earliest possible time, and fasciotomy of the anterior fascia cruris performed to allow space for the swelling. When the anterior tibial artery has been totally occluded, arteriectomy[12] is indicated.

Summary

1. Ischemic necrosis of the anterior compartment muscles of the leg is not common.

2. It is characterized clinically by swelling, pain, and redness over the anterior part of the leg, sometimes followed by necrosis and paralysis of the anterior compartment muscles.

3. It may or may not follow prolonged and exhaustive exercise.

4. The pathological picture is one of arterial fibrosis and degeneration of muscle tissue.

5. In mild cases, where pain is the only symptom and no redness or swelling is present, treatment consists of bed rest and leg elevation.

6. In those cases where pain is accompanied by slight swelling and mild redness, repeated lumbar sympathetic blocks every two days are advised.

7. In the acute, fulminating cases, a vertical incision over the anterior compartment is advocated as early as possible.

8. It is doubtful that penicillin is of substantial therapeutic value in this entity.

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[7] Horton, Bayard T., et al: An evaluation of methods and mechanical devices used in the treatment of peripheral vascular diseases. Arch. Phys. Therapy, 22:389-402, July, 1941.

[8] Montgomery, A. H. and Ireland, J.: Traumatic segmentary arterial Spasm. *J.A.M.A.* 105:1741-1746, Nov. 30, 1935.

[9] Ochsner, Alton and DeBakey, Michael: The rational consideration of peripheral vascular disease. *J.A.M.A.* 112:230-236, Jan. 21, 1939.

[10] Bywaters, e g l: Ischemic muscle necrosis. *J.A.M.A.* 124:1103-1109, Apr. 15, 1944.

[11] War wounds of the extremities. *Bull. U. S. Army M. Dept.* 76:61-71, May 1944.

[12] Leriche, Rene, et al.: Arterectomy. *S.G.O.* 64:149, 1937.

PENICILLIN IN INFECTIOUS SYPHILIS

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THE volume of literature on the treatment of syphilis with penicillin is tremendous. Experimental, clinical, and laboratory evidence is conclusive that this antibiotic drug is a most effective treponemacidal agent. However, the final evaluation of the efficacy of any antiluetic treatment cannot be made for at least a decade after the onset of its use.

Many dosage schedules of penicillin, alone and in combination, have been studied. The present trend is to combine penicillin with an arsenical and bismuth, giving all three agents concurrently in varying amounts. The additive effect of arsenic and heavy metal undoubtedly increases the efficiency of rapid treatment. The authors also have a series of patients treated with 2.4 million units of penicillin, 40,000 units given every three hours for eight days, plus a daily .06 oxyphenarsine (Mapharsen), and 1½ cc. of bismuth subsalicylate on the first, fourth, and eighth days. This series has not yet been analyzed.

All patients had pretreatment spinal fluid examinations, but the results are not reported in this paper. The importance of routine spinal fluid examinations in all cases of syphilis, regardless of stage, cannot be over-emphasized. We have had a few severe Herxheimer reactions, and several angioneurotic and urticarial reactions with penicillin. None were severe enough to discontinue treatment for more than one to four injections. Recently, benadryl and pyribenzamine have been found effective against allergic reactions to penicillin.

The purpose of this paper is to report a series of cases of early syphilis treated with penicillin alone. It is presented with the general practitioner in mind, hoping that a better understanding will be obtained therefrom.

Four different total unitage schedules have been used. Cases selected for treatment fell into three categories:

(1) Seronegative primary, diagnosed by clinical and darkfield examination,
(2) Seropositive primary, diagnosed by clinical, darkfield, and serological tests, and
(3) Secondary, clinical-seropositive cases.

Blood tests used were the Kolmer-Wassermann, standard Kahn and Mazzini and the Mazzini Quantitative.

There were 168 cases who received 2.4 million oxford units of sodium penicillin in aqueous solution, 20,000 units every three hours for fifteen days; 38 received 4.8 million units, 40,000 units every three hours for fifteen days; and 47 had 9.6 million units, 80,000 units every three hours for fifteen days. These treatment schedules are designated as "A," "B," and "C," respectively.

Schedule "A" was originally assigned to one of us (G.W.B.) in January, 1944, by the Syphilis Study Section of the National Research Council. It was followed according to the recommendations of the Council. The total unitage and time dosage schedule was to be maintained uniformly in each series. Twenty-six treatment schedules were assigned to some forty-three centers over the country.[2] In the event of infectious relapse the Council recommended retreatment with double the amount of the original assignment. Thus, schedule "B" (4.8 million units) is grouped alone. In January, 1946, after analysis, only seven of the twenty-six previous treatment schedules under study were continued. Schedule "C" (9.6 million units) was a quadrupling of our original dosage assignment. This was ordered in February, 1946. This quadrupled dosage was a result of evidence of lessened therapeutic activity, possibly due to the changing content of the various component fractions in commercial penicillin. All penicillin used was supplied by the National Research Council. The same brand and lot number was used to complete each case.

The criteria for selection of cases were: previously untreated early syphilis, clinically infectious, darkfield positive with pretreatment spinal fluid examination and quantitative serological tests, and periodic observation and tests over an extended specified posttreatment time.

Schedule "D" was not assigned until January, 1946. It was 9.6 million units of calcium penicillin in peanut oil and beeswax (Romansky formula), given by a single daily intramuscular injection of 600,000 units for sixteen consecutive days. Only ten cases were treated under this schedule.

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1. Committee on Medical Research and U.S.P.H.S.: A Joint Statement. *J.A.M.A.* 131, No. 4, pp. 265-272, May 25, 1946.
2. Heller, J. R.: Results of Rapid Treatment of Early Syphilis, *J.V.D.I.* 27, No. 9, pp. 217-225, Sept. 1946.

There were 263 cases treated with the four preceding dosage schedules. There were 96 white and 68 colored males, and 60 white and 39 colored females. The seropositive primary cases predominated, especially in the males. The increased incidence of secondary over primary cases in the female group in comparison with the male group is probably indicative of the greater tendency for the primary lesion to go unnoticed for a longer time in the female. Minute inspection of all of the folds of the genital mucous membranes under good light is essential in order to discover primary lesions in the female. Cervical lesions should be searched for by speculum examination. There were 62 cases of seronegative primary, 141 cases of seropositive primary, and 60 cases of secondary syphilis.

The greatest incidence was in the third decade of life, or during the period of greatest sexual activity. The presence of suspicious lesions in any person, regardless of age, should call for further study. Any genital lesion, regardless of appearance, history, or age, demands darkfield examination, as well as a complete serological and clinical follow-up.

A reasonable likelihood of permanence of local residency is an important factor in follow-up. As in any study of this type, good follow-up is very difficult. Patients receiving rapid therapy should be impressed with the fact that they are not always cured upon completion of treatment, and that regular and frequent examination with blood tests are necessary in order to determine their satisfactory progress. The patient receiving rapid treatment is too prone to develop a sense of false security. Every effort should be made to prevent this and to educate him as to his responsibility, his own welfare, and his co-operation.

There were five cases of reinfection. Rigid criteria for differentiation of relapse from reinfection were used. Serological upsurge, increasing prior to the appearance of lesions at previous sites, was classified as relapse. All doubtful cases were classified as clinico-infectious relapses although some were probably bona fide reinfections. Only cases with a sustained seronegativity, a known positive infectious contact exposure, and the appearance of new lesions prior to seropositivity were classed as reinfections.

It will be noted in this series, as well as in those to follow, that the number of retreated cases does not equal the number of relapses and reinfections. This is because some of the retreated cases received other types of therapy.

Schedule "A" is a composite picture of the results in 168 cases. No other adjuvant treatment was given, but only 2.4 million units total of aqueous solution of sodium penicillin, 20,000 units every three hours for fifteen days. An analysis of the results showed no change in serology in 16 cases (9.5 per cent). These were mostly seropositive primary cases which had been followed for less than one month and in whom no serologic change could be expected in that short interval. One patient with secondary syphilis had no change after 141-168 days. There was a declining serology measured by quantitative Mazzini as well as the standard tests in 44 patients (26.2 per cent). An upsurge in serological titre was shown in five (or 3 per cent) and probably preceded a clinical relapse. Consequently, these must be observed more frequently. Clinical and laboratory evidence of infectious relapse occurred in 11 (6.5 per cent) of the 168 total. These were all in the seropositive primary group. The absence of relapse in those with secondary may indicate the development of an increased natural immunity in these older, more generalized infections. The significance of this is often overlooked today. Syphilotherapists formerly placed a greater prognostic importance on this observation. All relapses ocurred in the 3 to the 7-8 months' posttreatment. This should be the period of special alertness in the follow-up.

Thousands of syphilitic patients were treated with penicillin in the armed forces during the recent war years. It has been stated that some 200,000 men were inducted with or acquired infection while in military service, and that another 200,000 were separated with treated syphilis or will acquire it. The importance of careful physical and serological examination of these veterans and service personnel at regular and frequent intervals cannot be too strongly emphasized. Many clinico-serologic relapses in veterans, treated in the service with penicillin only, have been seen by the authors. Much of this is due to the sense of false security imparted to these patients by over-enthusiastic or careless therapists.

The over-all results in thirty-eight patients treated with 4.8 million units follow. Due to the short period posttreatment, fourteen (36.6 per cent) had no serological change. There was declining serology in twelve (31.7 per cent). The same number and per cent were seronegative. There were three reinfections in this schedule. It is notable that there are no infectious or serological relapses in this dosage to date. It must be admitted that many of these patients have not been followed long enough to indicate superiority of this schedule. It does, however, indicate a trend in this direction.

Forty-seven patients received 9.6 million units, or 80,000, every three hours for fifteen days. Some authors believe that this dosage is surplus amount above the "saturation level" attained by 40,000 units every three hours. There was one reinfection in this series. In this case reinfection was definitely determined by previously mentioned criteria. There were five cases (10.6 per cent) with no change in serology. Here again this is due to the short follow-up period. To date we have had no relapses, either clinical or serological, and eight (17.0 per cent) had a declining serology, while thirty-four (72.4 per cent) were seronegative.

Ten patients were treated with 9.6 million units of calcium penicillin in peanut oil and beeswax (Romansky formula) as a preliminary study for comparison. They received 600,000 units in one daily injection for sixteen days. Of the patients receiving 9.6 million units in oil, three (30 per cent) showed no serological change, three (30 per cent) had declining serology, and four (40 per cent) are seronegative. All are clinically negative. There have been no relapses nor reinfections.

SUMMARY

The results of four different treatment schedules for the use of penicillin in infectious syphilis have been analyzed and presented. Patients were followed clinically and serologically from one to eighteen months after treatment. The study is presented to indicate a trend that higher dosages are probably advisable. This series is too small and too short a time observation period has elapsed to draw any final conclusions. The trend would also suggest that the general practitioner use penicillin as an adjunct to regular arsenical and bismuth therapy, rather than alone.

CONCLUSIONS

1. Satisfactory results were obtained in 81.0 per cent of cases treated with 2.4 million units of aqueous sodium penicillin, given 20,000 units every three hours for fifteen days. Indeterminate results were obtained in 9.5 per cent while unsatisfactory results were obtained in 9.5 per cent, also to date.
2. Satisfactory results were obtained in 63.4 per cent of cases treated with 4.8 million units over a fifteen-day period. Indeterminate results were found in 36.6 per cent.
3. In 89.4 per cent of those who received 9.6 million units of aqueous penicillin in fifteen days, there were satisfactory results. There are yet inconclusive results in 10.6 per cent.
4. In a very small preliminary series of ten cases who received 9.6 million units of penicillin in oil, 70 per cent showed satisfactory results and 30 per cent were inconclusive.
5. A trend is indicated that our higher dosage schedules are more effective in infectious syphilis. This is proved by the fewer relapses which occurred in these higher schedules.
6. The importance of frequent and regular clinical and serological examination of all patients receiving penicillin for syphilis is emphasized and especially in veterans who may have a sense of false security and final cure after their treatment in the service.
7. Penicillin alone should be used guardedly in the treatment of infectious syphilis.
8. The time of clinical relapse has usually been within the third to eighth month posttreatment period.
9. The results of therapy tend to be in very direct ratio to the duration of infection.
10. The failure rate with penicillin alone or in combination with subcurative amounts of arsenic and bismuth has been greater than with the intensive arseno-bismuth schedules. Its ill results or reactions are practically nil.

STRESS VERSUS PREDISPOSITION IN COMBAT PSYCHIATRY*

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MUCH has been discussed but little has been written and but few statistics compiled concerning which is the predominant etiological factor in combat psychiatric cases: combat stress or neurotic predisposition. The following statistics and opinions are offered with the thought that they might throw some light on the subject. The opinions are not to be taken as necessarily conclusive since they are formed by the author as a result of his study of several hundred psychiatric cases during six months of combat. Forty-eight of these were rejected in the statistical study because of inadequate interview or insufficient history. Most of the latter forty-eight passed through other Clearing Stations.

The statistics were compiled from the case histories of psychiatric disorders. All of the cases studied in Tables I and II broke down during the height of the German breakthrough in the Ardennes sector, between the dates of the 16 December 1944 and 1 January 1945. Cases occurring after the German offensive had been stopped (1 January 1945), to the date when the bulge had been erased and the original lines re-established (2 February 1945), were eliminated from Tables I and II (but not III), because the division was in static, defensive positions and therefore the factor of battle stress could not properly be evaluated in cases occurring in this period. Therefore, these February cases were also eliminated from the study in *all* the tables. During the period 16 December 1944 to 1 January 1945, the division was subjected to continuous severe offensive action from two German Panzer divisions and two Volks-Grenadier divisions on the north shoulder of "the bulge" in the Ardennes. Battle casualties were high and two

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or three necessary withdrawals of the lines had to be made due to the force of the German thrust. Hence, the factors of intense battle stress could best be studied in the cases occurring during this period.

The accompanying tables are fairly self-explanatory. However, some further elaboration is necessary.

Table I, showing zero to 4 plus degree of predisposition to breakdown, further adds to the concept that war neurosis occurring during combat are caused by war rather than neurotic predisposition alone. Spiegal and Grinker[1] in their paper state "No one is immune from a war neurosis under proper circumstances." Likewise, Herbert X. Spiegal, in his article reporting on psychiatric observations in the Tunisian Campaign, adds: "Mental breakdowns occurred in some who appeared stable" and "often a good leader enabled the unstable man to utilize what assets the soldier had, despite his unconscious conflicts." In the same vein of thought a letter from Capt. M. F. S. (serving in a hospital on Palau) to the School of Military Neuropsychiatry states: "One of the conclusions I drew from this series was that family history and previous neurotic trends, as revealed in the past history, have apparently no relation to time of onset and severity of symptoms. We would receive patients who broke severely after a few hours of combat whose past and family histories appeared negative, while a number of patients with a long bad past history lasted 20 to 30 days of steady fighting."

The fact that 52.7 per cent had no history of either family or past personal history of mental disease, neurotic predisposition, or psychopathic personality, tends to confirm the observations of Spiegal and Grinker and H. X. Spiegal, as related above. And actually, the sum of the percentages of columns 2 plus, 3 plus, and 4 plus shows that only 35.6 per cent of cases were definitely predisposed to early breakdown in combat.

All of the cases used in compiling Tables I and II had served with the division since it was committed to combat some forty days before the German offensive and most of them had been with the 99th for several months of its training, so they were not new troops or replacements. Thus Table I indicates that the 47.3 per cent with some neurotic predisposition or personality instability served as long as the 52.7 per cent with negative histories. Hence the idea of salvaging mild psychoneurotics and mild psychopaths.

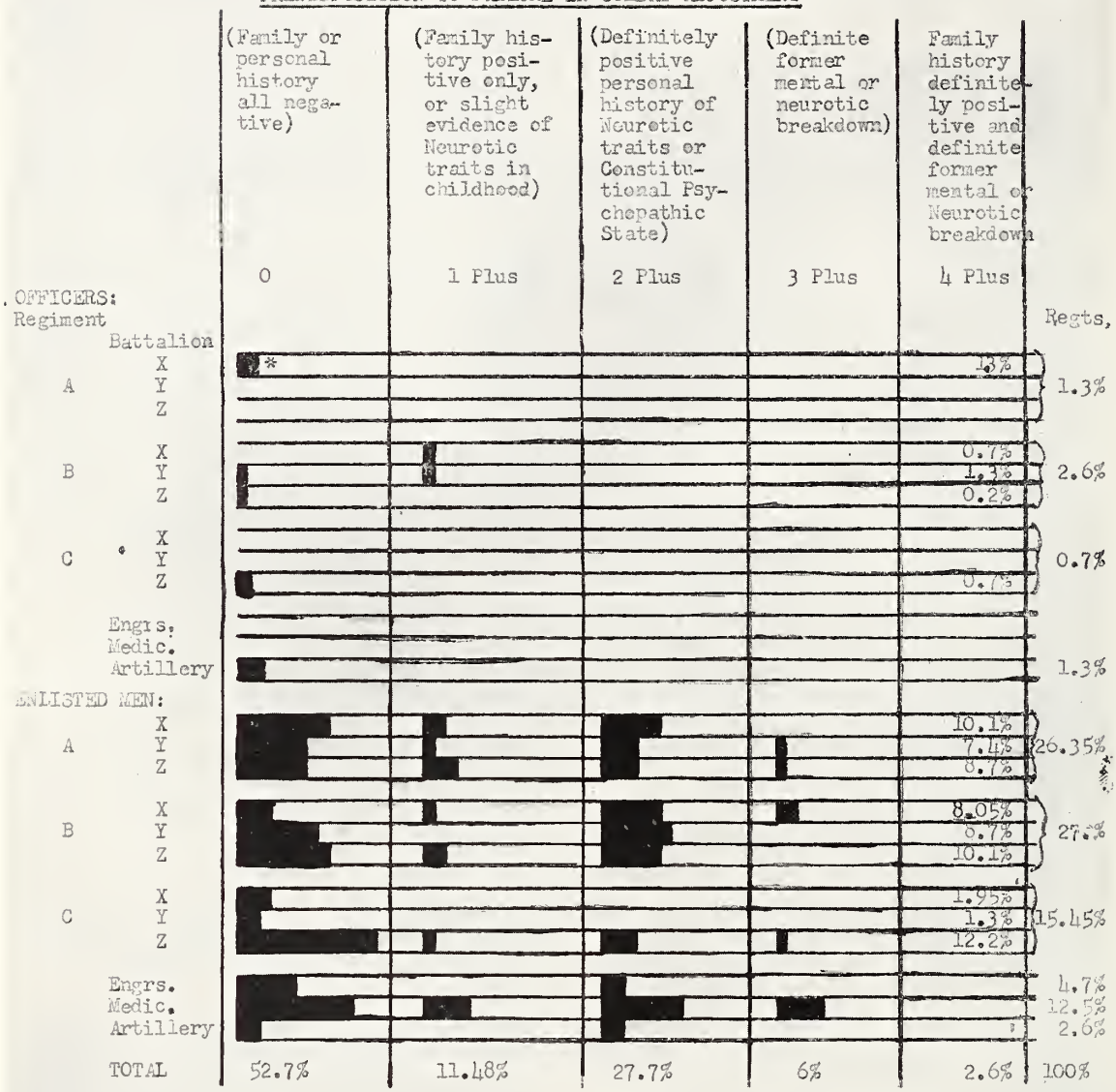
As other studies have shown, the front line riflemen of the infantry regiments form the bulk of the combat exhaustion cases. Although not shown in the table, with the exception of the medical department, noncombatant elements of the division had no C.E. (combat exhaustion) patients during this period of intensive combat, viz 16 December 1944 to 1 January 1945. One striking point noted is that actually the highest rate per thousand men during the period of study was in the medic group. Included in the medic group are all cases resulting in the medical battalion, the infantry regimental and battalion medical detachments, the Division Artillery and Artillery battalion detachments, the Special Troops medical detachment and the Engineer Battalion medical detachment. This total numbers about 750 men, yet 26 cases of combat exhaustion resulted in this group. An infantry regiment at full strength is approximately 3,000 men. So, the medics had about the same rate as the regiment C with the lowest rate per regiment (23 per 3,000). Practically all of these cases were in the litter bearers who work forward of the Battalion Aid Stations and Collecting Stations. Thus it appears by far the highest rate of combat exhaustion exists in the Medical Aid men and litter bearers. The probable explanation for this is that the aid man and litter bearer is unarmed. He cannot fight back. He must go out facing the same dangers as the riflemen, or sometimes even more when he goes out beyond the outposts to pick up the wounded. He often gets pinned down by the same mortar fire or shellfire as the man in the fox-holes, yet does not have the protection of the fox-hole when picking up the wounded. Experiences of American Psychiatrists with the Merchant Marine war neuroses, back in the days before the United States entered the war, strongly suggested that the war neurosis rate in the Merchant Marine was far less after the merchant ships were armed. Also, the litter bearer and medical aid man is attached often temporarily to a unit of infantrymen. He does not have the same feeling of group attachment, group protection, and group loyalty as do the rifiemen.

One striking thing seemed to be brought out in regard to the relative importance of leadership as far as the battalion commanders are concerned. Referring to Table II, battalions X and Y in regiment C did not have as good leadership as battalion Z, yet battalion Z had six times as many cases as either X or Y. However, battalion Z was in a position where it was subjected to heavy mortar and shell fire in attacks by the Germans and it repulsed numerous attempts of the Germans to break through. It held its position and received the presidential citation for this action. This tends to indicate that the number of C.E. (combat exhaustion) cases developing in a given unit in combat is directly proportional to the amount of punishment that has to be absorbed from the enemy, the amount of mortar and shell fire inflicted upon it, whether it holds its position or withdraws, et cetera. Leadership may not be so important among the battalion commanders as regards the number of C.E. casualties. It seems to resolve into the fact that if a unit doesn't have to *do* much it doesn't get hurt much, but when it has to stand up

(1) Grinker, Roy R., Lt. Col. M.C., and Spiegal, John P., Major M.C.; Brief Psychotherapy in War Neurosis. Psychosomatic Medicine, Vol. 6, No. 2, April, 1944.

TABLE I

PREDISPOSITION TO FAILURE IN COMBAT ADJUSTMENT



* Means proportion of the total number of cases, where 100% = the total number of cases which occurred during the period 16Dec '44 to 1 Jan '45.

and take it on the chin it has more casualties, both mental and physical.

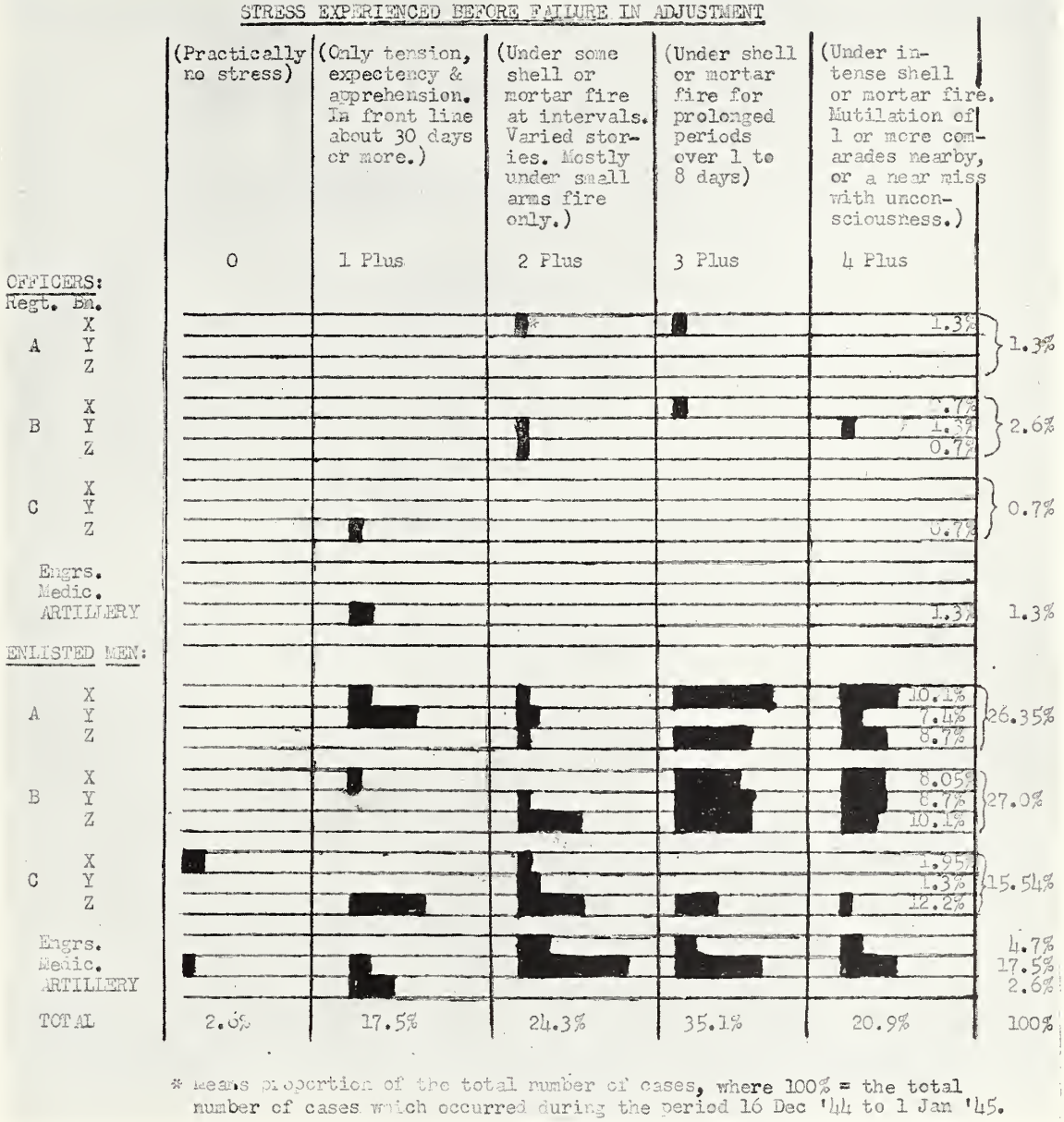
It may be added, however, that regiment C had higher morale and supposedly better regimental leadership all during its training phase and early combat. This probably accounts for the fact that the Regiment C as a unit had fewer C.E.s than either Regiments A or B.

Table II is self-explanatory. As can be seen, it breaks the division down into battalions and grades the C.E. (combat exhaustion) cases according to the degree of stress each was under as ascertained from both the patient's story of the situation existing when he broke down and the G-3 reports of the tactical situation at the time. Sometimes patients, especially C.E.'s, tend to exaggerate, so it is better to depend largely upon G-3 and officer reports of the action to confirm their story.

Checking Table I (predisposition) against Table II (stress before failure), it appears that grade 2 plus, 3 plus, and 4 plus stressful situations in Table II play the major role in the causation of

TABLE II

STRESS EXPERIENCED BEFORE FAILURE IN ADJUSTMENT



* Means proportion of the total number of cases, where 100% = the total number of cases which occurred during the period 16 Dec '44 to 1 Jan '45.

Combat Exhaustion breakdowns, whereas only the grade 2 plus, 3 plus, and 4 plus columns of Table I revealed enough predisposing factors to suspect early breakdown in combat but the factors of these latter columns were revealed in only a total of 36.3 per cent of the total cases.

The tabulation in Table III (concerned with entire six months of the division's combat period) demonstrates the relative number of combat exhaustion cases in certain actions and the per cent returned to full front line combat duty during these actions. It would seem from these figures that the greatest per cent can be salvaged for return to front line combat during the more successful action or during offensive action with but little resistance from the enemy.

The important problem to division psychiatrists and to the division is *not* the reports of the percentages of the various reaction types of combat exhaustion nor the number or per cent of cases returned to the Communications Zone, but it is the number of cases that can be salvaged after two to three days treatment at clearing station levels or Division Rear Rehabilitation Center, and returned to full front line duty. If a soldier can recover from an anxiety state or a mild hysteria and return to his place as rifleman in the front lines that is the greatest service psychiatrists can

TABLE III

	TOTAL	RETURNED TO FULL FRONT LINE DUTY	REPEAT CASES
TOTAL C.E.'s Nov '44 to 16 Dec '44 (Situation static-defensive position-patrol actions only)	*	80%	
TOTAL C.E.'s 16 Dec '44 to 1 Jan '45 (German offensive--heaviest action during the "bulge". 7,000 yard withdrawal. Heavy mortar and artillery fire.)		29.6%	
TOTAL C.E.'s 1 Jan to 1 Feb '45 Held position against enemy attacks. Offensive action to reestablish original lines present before the "bulge")		41.7%	
TOTAL C.E.'s 1 Mar to 11 Mar '45 (Offensive action with little resistence through Cologne plain toward Rhine.)		65.2%	
TOTAL C.E.'s 11 Mar to 27 Mar '45 (Offensive action with moderate to heavy resistance on the "Remagen" beachhead across Rhine--east side. Excellent Rest Center--Rear Platoon--Bodendorf spa--west side of Rhine.)		52.3%	
TOTAL C.E.'s 27 Mar to 8 Apr '45 (Rapid advance with but little resistance. No rest center operating until 8 Apr. Advanced around south side of Ruhr pocket and back west to wipe out east 1/3 of pocket.)		15.3%	
TOTAL C.E.'s 8 Apr to 17 Apr '45 ("Mopping up" action of east third of "Ruhr pocket". Division pinched off--out of action when it reached its objectives, 16 Apr '45. Rest Center functioning during this period.)		59.3%	
TOTAL C.E.'s 18 Apr to 8 May '45 (Rapid advance--across Danube south.)		39.1%	
GRAND TOTAL 9 Nov '44 to 8 May '45		44.2%	

* Length of bar is directly proportional to the number of combat exhaustion cases which occurred within each period of action.

render for the division, for the army, and for the war effort. It is believed by the writer that once a soldier leaves the Clearing Station Rear Platoon Rest Center, or Division Rear Rehabilitation Center, and is evacuated to either an Evacuation Hospital or Exhaustion Center, chronic war neurosis begins. "Abnormal fear" and/or physical or mental exhaustion (from combat tension induced by shellfire or being "pinned down" by machine gun fire for prolonged periods with inadequate food and rest) ends here and symptoms become fixed. The patient, being placed in the hospital atmosphere with sick or wounded or in the exhaustion center with sleepy, drowsy, patients, ataxic from heavy, prolonged barbiturate sedation, now believes himself really ill and unfit for further combat. Thus the stage of chronic war neurosis begins and usually, even though his symptoms may or may not vanish, they will return or increase once he is sent back into his old place as rifleman or litter bearer in the front lines.

COMMENT

Thus it is mostly preventative psychiatry that is practiced at the level of the clearing station: psychotherapy of explanation of the abnormal fear syndrome, the role of adrenalin, increased muscular tension; reassurance that the soldier (not patient) has not had a nervous breakdown but merely increased tenseness with fatigue and ex-

naustion; reassurance that he will be all right after two or three days rest; firm insistence that his outfit and buddies need his help; and, in some cases (psychopathic personalities with emotional instability bordering on cowardice), firm statements that it is honorable to stay in the lines in spite of fear but dishonorable to seek an escape mechanism. Also, with new reinforcements who have become anxiety states after only a few days or few weeks combat, explanation that they have not been properly seasoned to combat as yet or desensitized to the noise and the threats to their security, that their buddies, the veterans, have become "used to it" and that they can, in time; that they had a little overdose of hard combat at first but that the going will not be so rough at times, especially as they get more "seasoned to it"—all this helps to get the man back into his front line position where he is most useful. To let him go as an evacuee out of the division to a hospital setting is to set the stage for a chronic war neurosis and to fix his symptoms to suit his unconscious or conscious needs.

SUMMARY

1. It appears that the severity of the stress and the situation in battle is a far greater factor in the etiology of combat exhaustion than is predisposition to failure in combat because of neurotic or personality trends.

2. Apparently, stress is greater among unarmed litter bearers and front line medical aid men than in the front line riflemen, as suggested by the higher rate of combat exhaustion in the former group.

3. Leadership as far as battalion commanders are concerned is not so important in the prevention of C.E. (combat exhaustion) casualties as is the amount of punishment dealt by the enemy and absorbed by the unit. This tends to confirm the remark of a certain general, that "if you don't have to do much in a fight you don't get hurt much." However, by these statements the author does not mean to minimize the importance of good leadership in the maintenance of good morale in an outfit.

4. Table II indicates that it took a great deal of battle stress to break down most of the men who did break in this division, at least during the period studied (heaviest action yet sustained by the division—withdrawal action of 7,000 yards—during first half of period of German breakthrough, 16 December 1944 to 1 January 1945). These cases, being usually more severe, were more difficult to salvage. Also, the fact that general morale, although good, was not quite so high during the "breakthrough" as it was during other later offensive actions, made for lower salvage rate. Yet 29.6 per cent were salvaged for full combat duty in spite of these adverse factors.

5. Table III suggests that the number of C.E.'s are: directly proportional to the intensity of a given action, and dependent upon the type of action (greatest in a withdrawal; next great in numbers in an offensive action with heavy resistance; and least in number in a rapid advance with but little enemy resistance).

6. The per cent salvaged for front line combat was greatest in the actions likely to be more successful and in those where a better rehabilitation center was available.

7. The psychiatrist in wartime probably holds his most important position in the role of a preventative and "salvage" psychiatrist in the divisions of front line troops. However, only 5 per cent of the total psychiatrists in the armed forces are allocated for this work. It is felt that even better work could be done in the psychiatry of combat exhaustion in the infantry divisions, if at least three psychiatrists were assigned per division. One could be most effective working in liaison with all the battalion aid stations. Another would probably function best in the present assigned position at the clearing station to "weed out" the most severe cases who failed to respond to forty-eight hours rest, sedation, and psychotherapy. A third is needed to treat the mild "salvageable" cases at the rear platoon (reserve platoon) of the clearing station (when the division is mobile in a rapid advance) or to treat the more severe cases by pentothal narcosynthesis or more prolonged psychotherapy. This third psychiatrist could aid a line officer in his work rehabilitating "salvageable" cases with more training in: familiarization with weapons, patrolling, drilling, et cetera. This should instill more confidence in the soldier when he returned to the front lines.

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

Editorials

Christmas

CHRISTMAS, of the 1947 variety, promises far more than in recent years. What with war clouds over most of the world, this, the most delightful of all our holidays, has all but been eclipsed for many years. Now, however, the outlook is brighter; folks are again returning to a normal life, our stores and markets are becoming filled with the things that in past years we were wont to buy for our friends, all in remembrance of the Natal Day.



Our little folk, long denied many of the toys so dear to childish hearts, now are assured that when "Old Santa" makes his entry, via the chimney, he is sure to leave just what is wanted. For the oldsters, there is much to be thankful for; true it is that thousands of homes still mourn the loss of members in the Great Conflict, there remains much for consolation.

We have not given up on the "Prince of Peace"; we still believe that He will again come into His own and that the world will be brighter during the coming year.

So, THE JOURNAL wishes every one the traditional "Merry Christmas!"

THE NINETY-EIGHTH ANNUAL MEETING

THROUGH the palatial portals of Pluto's promenade passed 958 members of the Indiana State Medical Association, 441 wives and women guests, 98 men guests, and 121 exhibitors, a total of 1,618, for the ninety-eighth annual convention. Truly a very satisfactory representation and a record attendance for French Lick. From the standpoint of actual membership attendance it indicates a registration of approximately 26.8 per cent of the total of 3,583 members of all classes. This is an exceedingly good showing when one considers that French Lick is in the southern end of the state and the available facilities for a large gathering are definitely limited. As a matter of fact, it has reached the point where there is no city in Indiana which can provide adequate accommodations for the number of men who desire to attend these annual meetings.

The Committee on Arrangements did a splendid job in setting up facilities for the program and great credit is due the men who worked so tirelessly to see that everything clicked in proper sequence. An unusually attractive scientific program, in both the general and sectional meetings, featured many speakers from various parts of the country, as well as our own local talent. Attendance at these meetings was exceptionally good and interest was maintained throughout. The instructional courses exceeded their limits of attendance and provided excellent opportunity for brief refresher courses.

The technical exhibits were well located and presented ample opportunity for acquaintanceship with the newer drugs and therapeutic measures. Our association can be proud of the splendid cooperation of these exhibitors in providing, each year, such instructive and worth-while exhibits. Their representatives are uniformly courteous and eager to bring their products to the attention of the doctors, and their continued support is greatly appreciated.

The scientific exhibits, while few in number, exemplified a fine standard of accomplishment. Efforts will be made, in the future, to augment the number of exhibits and suitable awards are to be made for excellence in presentation.

Numerous breakfast, luncheon, dinner, and special meetings, of various groups, were well attended and presented an opportunity for the consideration of many worth-while projects. These included the Indiana Health Officers Conference, the State and County Conservation of Vision Committees, the Committee on Industrial Health, the State and County Anti-Tuberculosis Committees with the Indiana Chapter of the American College of Chest Physicians participating, the Veterans' luncheon meeting, the Committee on Secretaries' Conference, the Indiana Roentgen Society, the American Academy of General Practice, and various alumni, class, and fraternal reunions.

The Woman's Auxiliary conducted numerous meetings as well as a special luncheon and dinner gathering. A school of instruction was an interesting item on their program and the attention given to organization, administration, and public relations matters indicated the intense concern the members of the Auxiliary are giving to such subjects.

The social and entertainment features of the meeting reached an all time high. They began with the golf tournament, in which the winners were as follows: First low gross, Dr. B. A. Burkhardt, Tipton; second low gross, Dr. F. B. Mountain, Connersville; third low gross, Dr. R. R. Acre, Evansville; fourth low gross, Dr. K. T. Knode, South Bend; first low net, Dr. G. A. May, Madison; second low net, Dr. E. J. DeGrazia, Valparaiso; third low net, Dr. J. D. Coons, Lebanon; fourth low net, Dr. J. E. Walther, Indianapolis; fifth low net, Dr. J. N. Topolgus, Bloomington; sixth low net, Dr. W. S. Robertson, Spiceland; first blind bogey, Dr. George Row, Osgood; second blind bogey, Dr. J. T. Carney, Jeffersonville; third blind bogey, Dr. John Spears, Paoli; fourth blind bogey, Dr. Glen Ryan, Indianapolis; fifth blind bogey, Dr. J. C. Brown, Valparaiso; sixth blind bogey, Dr. T. V. Petranoff, Indianapolis. A trap and skeet shoot also was held, the winners of which were as follows: Trap Shoot: first prize, Dr. C. M. Donahue, Carmel; second prize, Dr. R. B. Engle, Winchester; third prize, Dr. John Lansford, Red Key. Skeet Shoot: first prize, Dr. Herman Combs, Evansville; second prize, Dr. John Lansford, Red Key; third prize, Dr. Frank Tyler, New Albany. The evening Stag Party was dispensed with in favor of an Inaugural Frolic for the physicians, their wives and guests, and proved a most acceptable innovation. The Orange County Grass Roots Band, a heterogeneous conglomeration of clashing cacophony, led off with a parade and a lot of noise to the extent that no one who was not already tone deaf could possibly escape becoming so. This served to put the audience in a most receptive mood for the excellent show which followed dinner. A very versatile Master of Ceremonies presented talent far and above the usual floor show run and, in addition, supplied a feature of his own which brought down the house. All in all, the meeting was off to a good start. The annual banquet, held on the evening of the last day of the meeting, was ably presided over by our president, Dr. Floyd Romberger. The principal speaker, Dr. Roscoe L. Sensenich, president-elect of the American Medical Association, brought to our attention some very interesting observations on "World Medical Trends." Dr. J. E. Ferrell, immediate past president of our state association, was presented with the Certificate of Merit of the association. The evening and the meeting was then closed on a most convivial note in the things Mr. Tom Collins of Kansas City had to say on "Price Tags on Progress."

Elsewhere in this issue will be found the reports of the various Committees, the Council, the Executive Committee, and the work of the House of Delegates. It continues to be a source of never ending amazement to us to witness the manner in which these various bodies operate. The intent interest and the dispatch with which the business of the organization is dealt with clearly indicates that the welfare of organized medicine in this state is constantly in mind, and its security in good hands.

Outstanding actions of the House of Delegates included the sponsorship of legislative action to require the informatory suffix of M.D., D.D.S., et cetera, where a prefix of Dr. is legally used. The resolutions seeking to establish sections on Industrial Medicine and Health, and on Diseases of the Chest were not passed. A new section on Gynecology and Obstetrics was created. The resolutions dealing with accrediting hospitals by the State Board of Registration and that expressing opposition to limiting staff hospital appointments to specialty board diplomates were combined to express the opinion that while rules and regulations were necessary, staff appointments should not be made on the basis of specialty board or special society membership. The resolution to co-operate with the Indiana State Nurses Association and the Indiana Hospital Association was passed. Aid in Rural Medical Care was confirmed and numerous other routine measures presented by various committees were passed. Considerable discussion followed the recommendation of the President that the offices of Vice President and Speaker of the House be added by Constitutional amendment. This was finally accepted, although a year must elapse before final action can be taken. The budgetary allotment of $2.00 per member to THE JOURNAL was increased to $3.00.

The address of the President-elect, Dr. Cleon Nafe, stressed the necessity for improvement in public relations, the need for uniformity of support of the open door policy in hospital staff membership, to the extent that individual qualifications must be the basis for acceptance or denial, the obligation of careful observation of other health organizations and the common support of our own medical organization, the increase of interest in the general practitioner, and the suggestion that an award similar to the Distinguished Service Award of the American Medical Association be given by our own state association.

Finally, the Presidential Address of Dr. Romberger, published in the November issue of THE JOURNAL, discussed many worth-while and pertinent issues and called attention to numerous ways in which the association might function to a better purpose. He recommended three specific changes, the addition of a Vice-President, a Speaker of the House of Delegates, and the selection of the city and date for annual meetings to be made two years in advance. His entire address was a forceful summation of the qualities that make for better medical organization and better medical care. His judgment, sincerity, and good common sense are clearly shown and every association member would do well to read his address several times.

The concluding meeting of the House of Delegates resulted in the election of Dr. A. P. Hauss of New Albany as president-elect for 1948. His qualities for organization and arrangements, and his insatiable ability to take great pains with whatever he attempts, speaks well for his term of office during the centennial year of 1949.

Dr. A. F. Weyerbacher, of Indianapolis, was re-elected treasurer, and will begin his seventeenth year in this position on January first. Dr. F. S. Crockett, of Lafayette, was re-elected delegate to the A.M.A. House of Delegates. Dr. W. M. Cockrum, of Evansville, was elected delegate to the A.M.A.

Section officers elected were as follows: Section on Medicine, M. E. Glock, Fort Wayne, chairman; S. L. Bryan, Evansville, vice-chairman; Paul J. Fouts, Indianapolis, secretary. Section on Surgery, William N. Wishard, Jr., Indianapolis, chairman; Harold D. Caylor, Bluffton, vice-chairman; Hawthorne C. Wallace, Crawfordsville, secretary. Section on Anesthesia, William H. Lane, South Bend, chairman; E. F. Bloemker, Indianapolis, vice-chairman; William B. Adams, Muncie, secretary. Section on Ophthalmology and Otolaryngology, R. J. McQuiston, Indianapolis, chairman; D. D. Yoder, Columbus, vice-chairman; R. P. Good, Kokomo, secretary. Section on General Practice, Eugene F. Boggs, Indianapolis, chairman; W. R. Tindall, Shelbyville, vice-chairman; Lester D. Bibler, Indianapolis, secretary.

The Indiana Board of General Practice of Medicine, Inc., held its annual meeting, and elected the following officers: Robert W. Gehres, of Shelbyville, president; Eugene F. Boggs, Indianapolis, vice-president; Maurice Lohman, Fort Wayne, secretary-treasurer.

Election of officers for 1948 at the Indiana Health Officers' Conference resulted in the following: William R. Taylor, M.D., Richmond, president; John W. Pahmeier, M.D., Sandborn, vice-president; Claude Dollens, M.D., Oolitic, secretary; and Morris Balla, M.D., South Bend, treasurer.

Thus ended the Ninety-Eighth Session. As it began, on a high note of anticipation, so it ended in a gratifying sense of satisfaction, of work well done, and of great hopes for the future.

IMMORTALITY

WITHOUT delving into the metaphysics of the subject, immortality, from a practical viewpoint, is characterized by remembrance.

Immortality for a physician may be of short or seemingly permanent duration. The annals of some physicians, like those of the poor, are short and simple. Remembrance for others—like Hippocrates or Galen—is truly of what is considered immortality.

Remembrance for some physicians lies in a name associated with a part of the human anatomy, like the tubes of Fallopius, the cells of Purkinje, the gland of Cowper, or the bundle of His. Remembrance may rest in the name of a disease such as Grave's disease, Bright's disease, Frölich's syndrome, or Friedreich's ataxia. It may find itself in the name of a procedure, as Webster's suspension operation, O'Dwyer's method of intubation, Mikulicz's resection, or Thiersch's skin graft. A surgeon's monument may be in the name of an instrument, such as a Rankin clamp, a Simpson forceps, a Gelpi retractor, or a Roger Anderson splint.

Among those at the top of the list of immortals are such names as Lord Lister, William Osler, and Walter Reid, and, although not physicians, Louis Pasteur, and Marie Curie. Immortality for them exists in the institutes and hospitals named for them, and in their textbooks and contributions to world literature. Added to these material things are memoirs of exemplary lives. Marie and Pierre Curie live not only in the many radium institutes established to their memory and in the naming for them of the unit of radium emanation, the millicurie, but in the story of a tender love eagerly taken to itself by a sentimental world. Bertram W. Sippy lives not only in the memory of his contribution to gastro-enterology, but in the deep affection kept for him by every student or young physician who was fortunate enough to know his friendship or to come under his teaching.

To the large group of suffering humanity the medical or surgical specialist in the large clinics of America is a man personally unknown to them. When a notice of his death appears in a newspaper, he is briefly remembered as the surgeon or medical consultant who saw the individual for a few fleeting minutes for some few days, or who at sometime or other took care of a relative or a friend.

It is the family physician who is remembered as a personal friend: someone who has often been known from the start of memory, someone who was ever present when trouble came to the family when one was a child, someone who was to be relied upon when one had a family of one's own. Not every country practitioner or family physician will be an Ephraim McDowell, a Crawford Long, or a James MacKenzie; but when he is gone, his immortality, his remembrance, is in the loving hearts of his former patients.

Of such is the immortality to which the young physician can aspire.

"DRINKING WELLS"

OF late there has been much discussion of an old problem, of which we have heard comparatively little in recent years, but with the housing situation being what it is new homes are going up all over the country, many of them without the corporate limits, necessitating some solution of the water problem for the new household.

The Marion County Health Commissioner, Dr. A. M. Hetherington, recently has issued some rather drastic orders concerning this problem; together with the County Building Commissioner he has ordered that all such building permits be held up until it is certain that "driven wells," rather than "dug wells," be provided for.

There can be no question as to the soundness of this policy; the old "dug wells" simply are outlawed—should have been many, many decades ago. To one who has lived for many years in Indiana—and this probably applies to most other states—the "dug well" is an institution. As a boy and young man, down around our beloved "Wild Cat Neighborhood," a driven well was almost unheard of.

Two or three men would take their spades and begin digging—this usually after the witch hazel, "water witch," had unmistakably located a vein for water, somewhere underneath the surface. Well, the digging went on and on until they "struck water." All too commonly that was the end of the well-digging—they had water and that was what they wanted.

Occasionally some well-to-do owner would have the well "bricked up"; this meant that common bricks were used to line the well, occasionally some placed in the bottom thereof. The bricks were loosely set, no mortar being used. Then a wooden cover was built, a hand pump installed, and there you had your dug well.

Occasionally these wells were d r a i n e d a n d cleaned, but we recall many instances in which such a well was left, as was, for generations. Back in those days, when one-room schoolhouses dotted every part of Indiana, each school had its own well. And on many occasions a few weeks before school was to open the Township Trustee delegated someone to clean out these wells. We well recall the various odors that accompanied these operations, as well as the not infrequent, more or less decomposed carcasses of the various rodents that had lost their lives therein, after the schools had closed in March.

For a period of several weeks water was carried to the school from nearby farms, until it was deemed safe to use the local supply. And those of us who were delegated to "go after water" felt highly honored.

There is no question that much of the typhoid, then so common in Indiana, came from these wells. Most of us, back in those days, knew little about the dangers of contamination of our drinking water from surface drainage. It was commonly noted that the "Chick Sales," the old type, if you please, were immediately adjacent to the family wells.

A long time ago, in conversation with the late Dr. John N. Hurty, who might well be named "the Pioneer Health Officer," he commented on this evil and remarked that if Indiana could get rid of the "dug wells," we would get rid of a lot of typhoid, as well as other infections.

In Marion County, in the last year, more cases of typhoid have been reported than for years past and Dr. Hetherington feels certain that poor water supply is the reason. We are inclined to agree with him in this and congratulate him on his effort to remedy a rather serious condition in Marion County.

UNCLE SAM AND HIS TAXES

WRITING under the caption, "Have Mercy, Uncle Sam," editor Wingate M. Johnson, editor of the North Carolina Medical Journal, comments on some recent happenings in his home State; it all revolved about the annual Narcotic Tax assessment of one dollar per holder.

It seems that — and this probably happens in every State—a few members were just a bit dilatory in sending in this one dollar, due on July first. Two of the doctors were unusually busy along about this date and each had serious illness in his family, so it is no wonder they slipped up on this appointment with Uncle Sam. One was just one day late in making the remittance, the other, a most heinous offender, was three days late in making the dead line.

About six weeks later they were advised by the Internal Revenue Collector of their delinquencies, who directed their attention to the fact that, under the law, they were liable to fines of not more than $2,000, plus imprisonment of not more than five years, or both!

Later, another little *billet-doux* from the Collector advised that even though the tax had been paid, tardiness in payment could not be overlooked and referred to a section of the law on "Compromise," which provided that a sum of not less than five dollars might clear up the situation. This money, by the way, could not be paid via the ordinary bank check, it had to be a cashier's check, a money order, or cash via registered mail.

Editor Johnson opines that the penalty is rather severe, since the interest demanded by Uncle Sam, in the one case, amounted to 500 per cent, and in the other 1,500 per cent

Well, it just goes to show that when we deal with Uncle Sam we will have to watch our knitting, and we are just now wondering, on learning that it is proposed that said Uncle take unto himself a wife, just how many more complications might arise.

Each physician eligible for registration under the Harrison Act is sent, some weeks prior to July first of each year, two or three reports to fill out; these are not extensive and take but a moment to complete. We recommend that this little chore be taken care of the very day the cards are received. By so doing many a headache may be avoided.

AN EXPLANATION AND A CORRECTION

IN the October issue of THE JOURNAL an editorial note appeared which referred to the budget for the Indianapolis General Hospital for the year 1948. This statement voiced the impression that the "budget for the coming year amounts to well over two million dollars, quite a sizeable sum for a city charitable institution." The information was gleaned from a clipping taken from an Indianapolis paper and was not checked for its veracity. Accurate figures supplied by Dr. Charles W. Myers, Superintendent of Indianapolis General Hospital, indicate that the total budget for the year 1948 is $1,643,737, which is an increase of only $186,048 over the budget of 1947. Since $400,000 of the budgetary amount is cared for by miscellaneous receipts, only $1,243,737 is to be raised by taxation. Consequently, the tax budget for 1948 is only slightly over $1,000,000 and not in excess of $2,000,000, as stated in the editorial note.

With reference to the statement that nurses were to receive an increase in pay of $65 per month, and various other employees were included in recommendations for salary increases, we were again misinformed. The total over-all salary increase was approximately 11 per cent.

Nurses salaries were increased to conform with the recommendations of the Joint Committee of the Indiana State Nurses Association and the Indiana Hospital Association. In certain instances, some nurses in the Department of Health, who were receiving pay for the lowest grade while holding supervisory jobs, were increased as much as $65 per month in order to conform to the recommendations of the Joint Committee of Nurses and Hospitals.

The total budget of the Board of Health and Hospitals for 1948 is $2,099,152.96 and provides for the operation of all Hospital and Health activities, including the Indianapolis General Hospital and seven other agencies and divisions of health control and activities.

Moreover, the budget for the Indianapolis General Hospital was supported by the Hospital Staff, the Board of Health and Hospitals, the Health Committee of the Council of Social Agencies, the Council of the Marion County Medical Society, the Indianapolis Chamber of Commerce, the Common Council of the City of Indianapolis, the Marion County Adjustment Board, and the League of Women Voters.

These statements of fact have been given by Dr. Myers in protesting the inaccuracy of the editorial note. In addition, we are informed that the Coun-

cil of the Marion County Medical Society, as well as the staff of the Hospital itself, not only approved the budget but actively supported and worked diligently for its acceptance.

In view of all this it just goes to show how wrong one can be in presenting information taken from a source where the reliability has not been thoroughly checked. No malicious intent was back of the article, and certainly no intent to censure the activity of the hospital staff, or of the Council of the Marion County Medical Society. The information at hand simply was incomplete and inaccurate.

We stand corrected and we regret particularly the feeling that THE JOURNAL was attempting criticism of an endeavor which was sponsored by the Council of the Marion County Medical Society. It is not the policy nor is it the wish of the editor, or his associate, or the editorial board to indulge in criticism of the approved activities of any county society. Neither is it their desire to underestimate the value of any worth-while and essential project instituted for the betterment of the care of the sick. We regret the impression given by the article, we were wrong, we're sorry, and we don't think it will happen again.

Editorial Notes

Judging from press reports for practically every part of Indiana, the "Fifty Year Award," recently instituted by the Indiana State Medical Association, has been well received. And well it might be, for fifty-year service to the people is something worthy of recognition. We have talked to a few of the recipients of this award and they are mighty proud of the recognition—and they should be—they have merited it!

Rheumatic fever, a condition that for many years was not so well known, now comes into the limelight of medicine, with the declaration that we must make war upon it. A rather insidious disease, affecting young people in their earlier years, later in life it proves to be the forerunner of heart conditions that all too often prove fatal. The American Heart Association, recognizing the serious import of this condition, has begun a campaign to control this menace.

The Third Pan-American Congress of Ophthalmology will be held in Havana, Cuba, January 4-10, 1948. An extensive program, with more than forty scientific papers, will be presented at this meeting, the speakers representing many foreign countries, as well as a notable list from this country. Dr. Derrick T. Vail, head of the Department of Ophthalmology of Northwestern University, will deliver the Harry Gradle Lecture, in honor of the founder and first president of the Congress.

Penicillin control of venereal diseases continues to command the interest of health authorities and the medical profession in general. From the reports continually being published, there appears little doubt as to its efficacy. Thomas Parran, Surgeon General of the United States Public Health Service, in a recent article in a lay magazine, makes the bold statement that a concerted national drive would make such diseases as rare as smallpox. Rather bold, that, but to us it seems most practicable. If we could interest General Public in this thing it might be that Dr. Parran's Utopian ideas could be brought into effect.

The January number of THE JOURNAL will be the "Year Book," a feature begun last year and one that proved immensely popular with our members. In this number will be an editorial concerning the ever-mounting costs of publication, showing that since 1941 there has been an increased cost amounting to several hundred per cent—and the end is not yet in sight, since our printers have warned us that 1948 will bring additional costs. Indiana finds itself in the same predicament as other states—an increasing cost being general over the country—just another instance of increased prices and costs in all fields. However, we find ourselves most fortunate in that we still have a good printing job, resulting in a magazine that will stand favorable comparison with any medical magazine published.

We still receive reports that a few Indiana communities have no resident physician, the latest to come to our attention is via the *Rockville Republican*, stating that the town of Waveland has no physician living and practicing there. It has been some time since we passed through Waveland, but we remember it as an enterprising community, situated in one of our best farming communities, not too far from larger cities and, in all, a good location for a young practitioner who wants to get started, right now.

The Auburn, Indiana, *Star*, in commenting on our comment in a recent number regarding the decline in the death rate for the "great killers" of a few decades ago, stated that "once a discovery is made and the worth of a cure proved, its effectiveness depends upon the willingness of the public to use it. Even today thousands of persons refuse to be vaccinated against smallpox and others neglect to have their children immunized so that diphtheria may be avoided." 'Twas ever so; preach the gospel of prevention, bringing incontrovertible proof that certain diseases can be controlled and prevented, there still remain hundreds who will not be convinced, who refuse to do anything about it; so it seems that it remains for us to keep on preaching, in the hope that some day we will have accomplished our end.

President's Page

Just Call Me "Rommie"

DRAW the word out a bit, evenly and softly, and I will recognize the voice of a friend. No, it will not offend: I love it. And it will mean much more to me than just a friendship; it will tell me in one simple word of salutation that you esteem my many years of effort on behalf of the great Indiana State Medical Association.

I never could wear a brass hat: it just doesn't fit rightly on my brow. And stuffed shirts are so uncomfortable! Why, indeed, are they worn? After all, each of us is just a cog in civilized society's machine! But, let's try to be nice cogs, good cogs, well-performing cogs, useful cogs, not mere idler cogs.

In Retrospect

The past year has been good to me. The often repeated expressions of confidence in my leadership gave me a mental and even a spiritual uplift which is difficult either to assay or to describe. I'm thankful. The great body of physicians, both as a whole and as individuals, also have been good to me, this because of their unswerving loyalty to and their unity of support of our great I.S.M.A. Most humbly and most unpretendingly, words alone do but poor justice to my sincere appreciation of their help and their encouragement. Though at times the task may have seemed hard and the pressures always constant and constantly perplexing, yet my part was a labor of love, love for our medical profession. The inward satisfactions and the mental exhilarations are but a small part of the reward for this service. Friendships, true friendships, make up the vast bulk.

The Future

As the pen writes and I realize that I am about to step from up-stage into the wings, my thoughts go to him who is to follow me in the main role of the cast. I have known him and worked with him these many years. He surely is presidential timber. Seasoned. Stout. Sturdy. I wish him well. He will give you good leadership. By virtue of long and active service, he is thoroughly acquainted with the internal machinery of your organization. He knows how to do and gets things done. Given the unified and re-enthused support of our membership as so well evidenced this past year, I predict great accomplishments for your association in 1948.

If the mellowing years of experience and observation and study have taught me but one thing about life, it is this: That which has made America great, that which has made American Medicine great, that which has made our own Indiana State Medical Association great, all can be summed up in one word: FREEDOM. Freedom of thought! Freedom of initiative! Freedom of debate! Freedom to solve our own problems in the truly democratic processes of free men! Whatever else may come, PHYSICIANS of INDIANA, REMAIN FREE!

In Au Revoir

The profession of this great state has bestowed upon me a rich experience, heaped up and over-flowing, one which I never shall forget. I can think for the moment of no better place to use it in the future years than as a rank and file member of my own, grass-roots county society, like a true soldier there to work happily, and I hope in peace, as a private under the able leadership of others. I trust that I may be permitted so to do. For, without a single quibble or a doubt, it is within the constituent county societies that we must find and encourage and develop and stimulate to aspire the future leaders of this, our great Indiana State Medical Association.

If I can help even in the least to do just that for any one I.S.M.A. member of our eighty-three county societies, then I shall be happy. Thus, while this is au revoir to this page, I wish it also to be another "hello" to all my friends throughout this great state, along with fistsfull of pleasant thoughts and kindly affections.

So, when we meet, just call me "ROMMIE."

Sincerely,

Floyd L. Romberger

Convention Notes

Congratulations to Dr. Floyd T. Romberger, "Rommie" to you, for the excellent manner in which he handled his presidential duties at the annual session. Now there's a boy who should go far in the halls of any legislative gathering. Forceful, dignified, lucid, and to the point. All that and more characterized the splendid delivery of his presidential address, his deliberations with the House of Delegates, and his cordial presiding at the annual banquet. The rising vote of appreciation given by the Delegates at the final session of the House was a sincere tribute to the worth of the man who has labored so hard and so long in organized medicine. He has made a firm imprint upon the historic progress of the "great Indiana State Medical Association," and his name will long be remembered as a leader and influential sponsor of all that is good in medicine.

Dr. and Mrs. Roscoe L. Sensenich were gracious hosts to many of their friends who came to convey their best wishes and congratulations. "Ross" wears the mantle of president-elect of the American Medical Association in a most becoming manner and it couldn't have happened to a nicer guy or one more capable.

No finer tribute could be expressed and no potential recipient found more worthy than the nomination of "Jake" Oliphant to receive "the medal of the American Medical Association for exceptional service by a general practitioner." No doubt there are many fine, outstanding family physicians scattered throughout the land whose record of medical service in their community has earned the respect and appreciation of their patients and colleagues. We can't help feeling partial, however, because to us "Jake" represents all of the fine qualities that go to make an outstanding general practitioner. His service to his community, as well as his untiring efforts in the cause of organized medicine, his splendid personality, and the affection in which he is held by his own townsmen rank him in the vanguard of those great practitioners of medicine—the family doctor.

We note again the impressive ceremony of the presentation of the Certificate of Distinction and the gold lapel button to those men who have achieved 50 years of medical practice. This tribute was most happily received and is a splendid recognition for the men who have worked the greater portion of their lives in the field of medicine.

I.S.M.A. Presidents—Past, Present, and Future



Standing, left to right: Cleon A. Nafe, N. K. Forster, F. S. Crockett, F. T. Romberger, A. M. Mitchell, Herman M. Baker, George Daniels. Seated, left to right: Jesse E. Ferrell, R. L. Sensenich, C. H. McCaskey, Charles N. Combs. (In the background: Ray E. Smith and Bert E. Ellis.)

The Council



Left to right: C. B. McCaskey, F. T. Romberger, W. H. Howard, Alfred Ellison, A. M. Mitchell, Paul Garber, C. S. Black, E. H. Clauser, I. C. Barclay, C. J. Clark, W. U. Kennedy, A. F. Weyerbacher, Albert Stump, Cleon A. Nafe.

In addition to out of state speakers and guests of the association, we were honored in having Dr. Elmer Henderson, Chairman of the Board of Trustees of the American Medical Association, and Mrs. Henderson, present for the annual banquet.

The date set for the next Secretaries' Conference was February 15, 1948, at Indianapolis. This is a most worth-while meeting and every county society should have its representative present.

A novel feature that attracted much interest was the display of baby pictures of various members of the Association. Under the title of "Doctors Then and Now," the Woman's Auxiliary had gathered a great many pictures of members taken in their youth, and combined them in a display. Members and guests were asked to vote for their choice under various headings. Prizes were awarded on the basis of the balloting and were won by Drs. Van Buskirk, Amy, Culbertson, and Forster. Some one said: "The only reason Cy Clark didn't win a prize was because he must have put in a ringer. No one who looked so pretty in that picture could posssibly have grown up to look like Cy does now."

Seventeen out of twenty-one living past presidents attended the meeting. Quite a record. The list included William H. Stemm, William R. Davidson, Charles N. Combs, George R. Daniels, Franklin S. Crockett, Joseph H. Weinstein, Everett E. Padgett, Roscoe L. Sensenich, Herman M. Baker, Edmund M. Van Buskirk, Karl R. Ruddell, Albert M. Mitchell, M. A. Austin, C. H. McCaskey, J. T. Oliphant, N. K. Forster, and J. E. Ferrell.

The Association and THE JOURNAL is indebted to Dr. A. C. Remich of Hammond for the fine group pictures taken at the meeting. It seems he was everywhere and we regret the impossibility of printing all of the fine "shots" he provided.

Genial Tom Hendricks, emeritus executive secretary of the association, and now secretary of the Council on Medical Service of the American Medical Association, was all over the place, greeting old friends and being greeted in turn. That boy never seems to grow a day older.

The Orange County Grass Roots Organization put on a most effective and instructive induction for the members. Successful completion of the examination resulted in certification as a "Diplomat cum louder." The examination was mighty tough but all who took it survived.

No report of this meeting would be complete without a word of appreciation to Ray Smith for the excellent manner in which he conducted the business affairs of the session. If there was any criticism, none of it could be directed against our Executive Secretary. The mass of detail connected with a meeting of this kind seemed to unfold in perfect, orderly sequence and witnessed the careful planning and arrangement which he supervised. In the confusion attendant upon any large gathering Ray maintained his even manner and we have yet to see him rattled or upset by anything. Congratulations, Ray.

Dr. A. P. Hauss and Dr. C. E. Boyd, co-chairmen of the Committee on Convention Arrangements, certainly did a grand job in carrying out the numerous duties connected with such a job. Their committee outdid itself in preparing for every contingency. Praise, too, is due the Reception Committee, the Inaugural Frolic Committee, the Fraternity and Class Reunion Committee, the Housing Committee, the Women Physicians Committee, and the Women's Entertainment Committee. Working under the direction of the Arrangements Committee, every one of these committees functioned perfectly. We congratulate the members of the Orange County Medical Society and of the Third District upon a splendid job, well done; and we want to take this opportunity to say—thank you.

Dr. Paul R. Tindall, Secretary of the State Board of Medical Registration and Examination, reported on the progress of the board under the new registration law. He indicated that the Attorney General had ruled that the individual, not the license, was registered and hence the medical group would not have to furnish evidence of payment of poll tax. Service men are to be shown consideration, in that the board will waive the penalty clause for failure to register. Some 3,782 physicians have registered and about 50 or 55 doctors were required to pay the penalty fee because of misunderstanding or laxness. In the matter of licensure, osteopaths are required to pass the same examination as doctors of medicine, according to a ruling of the Attorney General. Since 1897 some 15,000 certificates have been issued by the board.

Two Popular Past Presidents



J. T. Oliphant, of Farmersburg, and N. K. Forster, of Hammond.

President-Elect—1948



Drs. Augustus P. Hauss and William H. Garner, of New Albany, seem equally happy over the results of the election of president-elect.

Continued efforts are to be directed toward the goal of bringing the first year of medicine to the Indianapolis campus. Dean Van Nuys of the Medical School addressed the House of Delegates and made a very stirring talk. His impression upon the House was most favorable and it was a great sense of satisfaction to know that the direction of the policies of the medical school remain in such capable and progressive hands.

The hotel management deserves a warm "thank you" for the excellent manner in which they cooperated, for the fine service rendered, and for their handling of arrangements. All of these under the trying circumstances of caring for such a large number. The entire hotel was turned over to the doctors, even the quarters of the assistant manager and of the executive personnel were turned over for the benefit of the members. Private homes, tourist cabins, small hotels, and all other facilities were utilized. You can't beat that for trying.

At the annual banquet a drawing was held for various door prizes. First prize, donated by the hotel management through Mr. Kelly, consisted of a cancellation of all hotel charges. The lucky winner was Mrs. E. M. Van Buskirk, wife of our past president. After the dinner Van was found silently brooding over the situation. When asked why he was so downcast he replied: "Well, you know when we arrived they gave us a nice $24.00 a day room. But Mrs. Van is a little conservative and had us moved to an $18.00 room. Now we win this prize. There ain't no justice!"



Drs. Henry N. Harkins, of Seattle, and George T. Pack, of New York, out-of-state speakers, and Dr. J. C. Katterjohn, of Indianapolis.

The Editorial Board of THE JOURNAL met and numerous suggestions were brought forth for improvement of reader interest and the betterment of THE JOURNAL generally. President Romberger attended the meeting and presented several worthwhile suggestions. The coming Year Book was discussed and as a result this issue should be bigger and better than ever.

Numerous suggestions have been made looking toward the improvement of the scientific sessions. Jack Jones feels that it would be a progressive step if all sectional meetings were to be combined in general meetings at which each section could sponsor two or three papers. In this way all the members could attend those papers they desire to hear. In this connection, many favor the panel form of discussion.



Dr. F. T. Romberger, Dr. Elmer Henderson, chairman of the Board of Trustees of the A.M.A., and Dr. M. B. Catlett.

If you really want to have a most enlightening discussion on almost any topic, sit down with Albert Stump. We had the pleasure of having breakfast with him. Lordy! that man can talk about anything from literature, art, music, sculpture, medicine, law, dentistry, politics, foreign policy, down or up to and including higher mathematics, Einstein and the atomic theory. His fund of exact information is truly astounding.

The association was honored in the attendance of Dr. R. L. Rutledge, president of the Ohio State Medical Association. He addressed the House of Delegates and extended a cordial invitation to the officers and members to attend the Ohio State Convention.

So endeth the report of the Ninety-Eighth Annual Session.



Drs. C. H. McCaskey and Hert E. Ellis, of Indianapolis, and Dr. Alfred Ellison, of South Bend.



Dr. Marvin McClain, of Scottsburg, and Dr. Claude M. Donahue, of Carmel.

THE GREAT FRENCH CLINICIANS OF THE EARLY NINETEENTH CENTURY*

WILLIAM M. LOEHR, M.D.

INDIANAPOLIS

WHAT a remarkable one hundred years in the history of medicine the nineteenth century was! A medical "March of Time," covering the period 1800-1899, could, with the motion picture technic of photomontage, delineate for us the major achievements. We would see the ailing and feverish Laënnec singlehandedly establishing modern clinical medicine with the stethoscope; the first use of ether anesthesia as an adjunct of surgery, taking place in the domed surgical amphitheater of the Massachusetts General Hospital, would appear; next our eyes would pick out the modest laboratory of physiology at the Collège de France where the incomparable Claude Bernard for twenty years has been discovering dominating facts, not only more facts than the few French physiologists working beside him, but more facts than all the physiologists in the world. This remarkable student of the phenomena of life and the philosophy of the organism is laying the foundation of experimental medicine, or the artificial production of disease by means of chemical and physical manipulation, which has made possible the remarkable medical victories of our present century. We would quickly identify William Beaumont by his uniform of Surgeon of the United States Army, studying the digestive processes of the stomach through the permanent gastric fistula of Alexis St. Martin at Fort Mackinac, Michigan, and for the first time in medical history observing gastric digestion in process. Virchow would be seen lecturing in the new Pathological Institute of the University of Berlin, in the presence of a somewhat numerous assembly of medical men, for the most part physicians practicing in the town. He is lecturing on the processes of disease in terms of cells and cell activities. The influence of this material (published in 1858 under the title "Cellular Pathology") and the influence of its author on medical and scientific thought can hardly be over-estimated. The work still stands, quoted by writers today as if it were a modern text. Into clear focus come the kindly, gentle, and magnificent features of Lord Joseph Lister, who, realizing through Pasteur's researches, that the formation of pus was due to bacteria, proceeded to develop antiseptic surgical methods, with results of such beneficence as to make it rank as one of the great discoveries of the age.

Surely one would think the foregoing procession of illustrious men and their achievements would be sufficient for any one century, but the closing years of the amazing nineteenth century furnished yet additional giants to be portrayed on our imaginary photomontage. There is Roentgen setting up his apparatus in one of the smaller laboratories of the Physical Institute of the University of Wurzburg. It is a simple apparatus and yet destined to become the instrument of discovery of the phenomenon which forms the corner-stone of the lofty structure of roentgenology that has been erected by workers in the natural and medical sciences. Looking at the bare and unassuming laboratory, we are struck by the thought that in the great march of science it is the genius of man, and not the perfection of appliances, that breaks new ground in the great territory of the unknown. The same thought is emphasized even more forcefully as our montage fades out on the figures of Pierre and Marie Curie, working over literally tons of pitchblende in a wooden shack, an abandoned shed, with a skylight roof in such bad condition that it admits the rain. Here ingenuity was to make up for wealth, and our last view is of Marie stirring a mass of boiling matter with an iron rod nearly as big as herself as she and her husband set about the chemical separation of radium and polonium and study the radiation of the products thus obtained, ushering in a new age not alone in science but in civilization—our present Atomic Age.

As the image fades we can say as did our beloved Harvey Cushing, "Though lives die, the life is not dead; and the memory of lives such as these will be reverently and forever shared not by a profession alone, not by a nation alone, but by the universal brotherhood of man."[1]

The great and broad advances in medical thought contributed by the nineteenth century immortals just enumerated gave to medicine countless inventions and technics of applied science as the outgrowth of the full and complete utilization of the experimental method by innumerable workers throughout the world. Thus, our documentary medical "March of Time" could quickly flash before our eyes: (1) the introduction of instrumental precision into medicine on a grand scale (the stethoscope, the sphygmomanometer, the ophthalmoscope) —all the complex diagnostic precision instruments of today, from audiometer and electrocardiograph to radioactive isotopes and the x-ray; (2) the triumphs of bacteriological methods and technics in separating and differentiating the great group of contagious fevers and the development of serum-

* Presented before the Indiana Association of the History of Medicine, in Indianapolis, October 1, 1947.

[1] Cushing, Harvey: Address at the Lister Centenary Celebration, July, 1927.

therapy, antitoxins, chemotherapy, and antibodies; and (3) the development of the modern public health laboratory in all that the term implies. As these scenes appear on our imaginary screen we can hear the crisp words of the narrator speaking as follows: "Thomas Carlyle was fond of calling man 'a tool-making Animal. . . . Weak in himself, and of small stature. . . . Feeblest of bipeds. . . . Nevertheless he can use tools, can devise tools. . . . Nowhere do you find him without tools; without tools he is nothing, with tools he is all.'" As these words die away we are fascinated by the thought that it hasn't been much over one hundred years since the day when what a patient said and what the physician saw and felt were all that a case of disease had to tell the clinician. Today the clinician uses as many instruments and tools as a mechanic, but, however much he gains thereby, his tools are not labor-saving. They force him by the time their use exacts to learn to be rapid and at the same time accurate. Today our manifold precision instruments have given birth to new standards of observation, by which we live, scarce conscious of the change even a generation has brought about. We of the twentieth century are but pushing farther back the many doors opened and left ajar by the giant intellects of the nineteenth century.

For the growth of scientific medicine the nineteenth century opened auspiciously. The awakening came in France. Up to the year 1850 and well beyond it most of the advancements in medicine were made by the French. In 1801 Marie-Francois-Xavier Bichat published his *Anatomie descriptive*, in which he placed the seat of disease, not in the organs, but in the tissues or fabrics of which they were composed. This gave an extraordinary impetus to the investigation of pathological changes. In this year of 1801 the immortal Laënnec was twenty years old and had come to Paris from Quimper in Brittany to begin his formal medical training. He was faced with a choice of clinical professors. Jean Corvisart, with his doctrine of clinical anatomy and descriptive pathology, was teaching at the Charité. Philippe Pinel—who stands so high in medical history as the first to treat the insane in a humane manner—was teaching his purely philosophical doctrine of disease classification (in which diseases are classed much as a botanist classifies plants) at the Salpêtrière. Laënnec elected to study with Corvisart at the Charité and there can be no doubt that this fortunate choice had everything to do with the proper direction of Laënnec's talents along the lines of pathological anatomy. Consider for a moment the ages of the chief clinical teachers in Paris in the year of 1801: Bichat at Hôtel-Dieu thirty years old; Corvisart at the Charité forty-six years old; and, Pinel at the Salpêtrière, the oldest, fifty-six years of age. The youthfulness of these heads of medical services was no small factor in the rapid development of French clinical medicine.

What might be called a third school of medical thought was also in existence, headed by Francois Broussais. His arbitrary doctrines, that gastro-enteritis was the basis of all pathology, that nature had no healing power and that, therefore, it was necessary to leech the body drastically, were the sheerest metaphysical theorizing, and, as you have no doubt by now anticipated, were soon exploded by the patient and persistent scientific collection of facts by the following men:

Pierre Louis, internist at the Hopital de la Pitié, was one of the most tireless workers to make clinical medicine scientific, and published a long list of accurate and important researches between the years 1825 and 1835. He demonstrated the great frequency of tubercle in the apex of the lungs; gave typhoid fever its present name *(fièvre typhoïde)* in an important communication in 1829; and by applying statistical proof and statistical studies in medical investigations he was the first internist to establish medical, as distinguished from vital, statistics. As a practical innovator he was the first clinician (after the Englishman Floyer in the eighteenth century) to use the watch in timing the pulse. And what should be of most interest to us is his great influence, as a masterful clinical teacher, on our most successful early American physicians. The medical historian Garrison says, "Through his American pupils, Holmes, Gerhard, the Jacksons, the Shattucks, and others, he exerted a powerful influence upon the advancement of medical science in the Eastern United States. The strong stand which Louis took in favor of facts and figures as against the sterile theorizing of the past appealed especially to the keen, practical common sense of these northern physicians."

Gaspard-Laurent Bayle, the best friend and, perhaps, the best-liked colleague of Laënnec, established a remarkable reputation in pathology, particularly the pathology of tuberculosis. His life's work is found in his publication *"Researches on Pulmonary Tuberculosis"* (1810), for he died of the disease himself in 1816 at the age of forty-two. He was another of the great intellects of this period stressing the importance of pathological anatomy in the explanation of disease, and his work may be summed up by a brief quotation from his classical book. He said, *"Il n'y avait pas de phthisie sans tubercule."* (There was no tuberculosis without tubercle.)

Another contemporary of this brilliant French school was Pierre Bretonneau, who, at the time Laënnec was writing the second edition of his book on auscultation, was giving the disease, diphtheria, its present name (la diphtherite), and performing the first tracheotomy in croup. In addition, he located the typhoid lesions in Peyer's patches as early as 1820 and made the prediction that typhoid would some day be differentiated from typhus fever.

One of the ablest diagnosticians among this exceptional group of men was Jean-Baptiste Bouillaud, who, seventeen years after Laënnec's monumental work on auscultation, applied the stetho-

scope to cardiac diagnosis with, perhaps, a little more thoroughness and detail than did Laënnec. However, one would be ill-mannered indeed, after all that Laënnec did for the physical diagnosis of respiratory diseases, to criticize in any way his partial success with cardiac diagnosis. Laënnec was grounded in pulmonary pathology, Bouillaud in cardiac pathology. Bouillaud produced also an important treatise on articular rheumatism and pointed to the frequent occurrence of heart disease with acute articular rheumatism.

Thus, by the year 1840 an exceptional group of clinical observers—for the most part young men—had by diligent correlation of pathological anatomy with clinical findings prepared a firm foundation for internal medicine. These bold and willing workers showed that internal medicine could not advance as a science "by hugging some pet theory out of regard for its author's personality," but could advance only by virtue of a vast amount of pathological, physical, and biological research. Thus clinical medicine was prepared to hit its full stride after the middle of the century, when it was to receive the great impetus of Claude Bernard and his contribution of experimental medicine.

Jean Nicholas Corvisart, as has been mentioned, was Laënnec's teacher at the Charité. He was also the Emperor Napoleon's favorite physician. The three men whom Napoleon respected most for their honesty and frankness were Corvisart, Larrey, and Percy, all of whom were physicians. Although his name has been immortalized by his relationships to Auenbrugger and Laënnec, he was a great master in his own right. He was akin to those of us who worked our way through medical school as hospital orderlies. Having neither money nor influence he obtained a position as male nurse at the Hôtel-Dieu, where he received board and lodging and was given an opportunity to study medicine. He graduated in 1782 the first in his class—and the youngest. When the Medical Faculty of the University of Paris was created in 1795 he was chosen to fill the chair of medicine. In 1806 he published his *Essaie sur les maladies et les lesions organique du coeur et des gros vaisseaux*. Here cardiac symptomatology was emphasized and the differentiation between cardiac and pulmonary disease was made. The physical signs of aneurysm were clearly defined and the first description of the pre-systolic thrill of mitral stenosis was given.

In 1808 Corvisart translated Leopold Auenbrugger's book on percussion into French, annotated it, and commented upon it. Auenbrugger's little book of 95 pages grew into a volume of 440 pages. In 1761 Auenbrugger had published his treatise, *Inventum Novum*, in Latin, under a rather cumbersome title which may be translated as, "A new discovery in order, by percussion of the human thorax, to discover signs for the recognition of hidden diseases of the Chest." Half a century had to elapse before clinical medicine was ready to adopt percussion as one of its most valuable diagnostic methods. Percussion was not immediately adopted in 1761, for the obvious reason that pathological anatomy was not advanced enough. Auenbrugger was decidedly ahead of his time. His treatise with the cumbersome Latin title gathered dust on the library shelf. Corvisart developed percussion in the French clinic to its fullest extent. He presented Auenbrugger's work as a translation and as a translator, in no way claiming originality for the discovery. With a fine sense of integrity he states in his preface to the translation, "Knowing well the little glory devolving on nearly all translators, as well as on great numbers of commentators, I could have elevated myself to the rank of an author by recasting the work of Auenbrugger, and by publishing a work on percussion. But by that, I would sacrifice the name of Auenbrugger to my own vanity, that I did not wish: it is his, his beautiful and legitimate discovery (*Inventum Novum*, as he justly speaks of it) that I wish to revive."

It is this priceless 1808 edition of Corvisart's book that is shown in Figure 1.

Jean Cruveilhier received his M.D. degree at Paris in 1816, having been a pupil of the great Dupuytren who had succeeded Bichat at the Hôtel-Dieu after the latter's untimely death. Cruveilhier was for thirty years professor of pathological an-

Figure 1

NOUVELLE MÉTHODE

POUR RECONNAITRE

LES MALADIES INTERNES

DE LA POITRINE

PAR LA PERCUSSION DE CETTE CAVITÉ,

PAR AVENBRUGGER,

Médecin ordinaire de la Nation Espagnole dans l'Hôpital impérial, à Vienne en Autriche;

OUVRAGE TRADUIT DU LATIN ET COMMENTÉ

PAR J. N. CORVISART,

Premier Médecin de S. M. l'Empereur et Roi, Offic.er de la Lég. d'honneur, premier Médecin hon.re et premier Médecin consultant de S. M. le Roi de Hollande; Commandeur de l'Ordre Royal de Hollande; Professeur hon.re de médecine clinique à l'École de Paris, Professeur hon.re de médecine au College de France; Médecin de l'Hôp. de la Charité; Associé hon.re de l'Académie Imp.le Joséphine de Vienne, de la Soc. Roy.le de Naples, de la Société Méd.le d'Emulation de Paris; et Membre de la plupart des Sociétés savantes de l'Empire.

Insonuêre cavæ....
VIRG., ÆNEID.

A PARIS,
DE L'IMPRIMERIE DE MIGNERET.
1808.

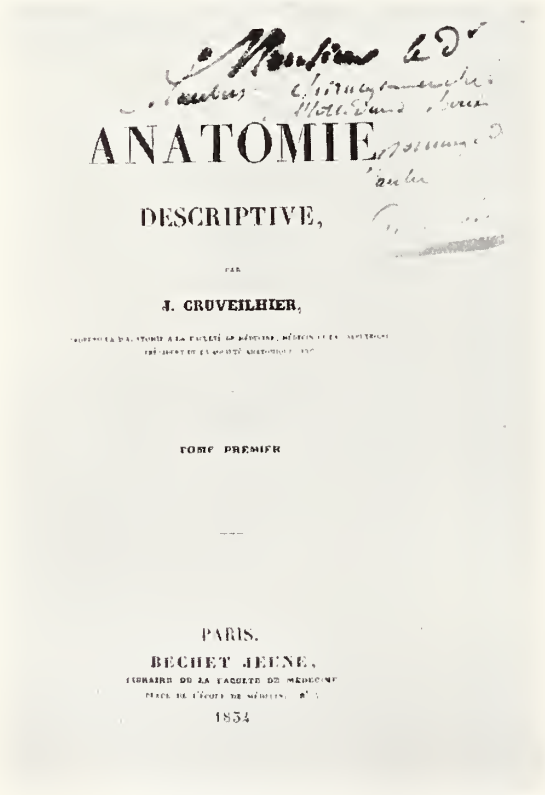
Figure 1. Title page of the author's copy of the 1808 edition of Corvisart's translation into French of Auenbrugger's book on "Percussion of the Chest."

atomy at the University of Paris and published remarkable books on pathological anatomy, and is remembered especially for his classical description of gastric ulcer, which is still called by the French "la maladie de Cruveilhier." In 1934 Cruveilhier published his Treatise on Descriptive Anatomy, which was remarkable for its clarity, brevity, and accuracy. This first edition did not contain figures or illustrations but was followed by a most beautiful edition which was illustrated handsomely, and which for many years was the textbook of anatomy students of the nineteenth century. His atlases of pathology, from the artistic standpoint, have never been excelled. Unfortunately Cruveilhier did not use the microscope and his errors were later corrected by the immortal Virchow.

An autographed edition of the great French anatomist's first edition of his *Descriptive Anatomie* is shown in Figure 2.

Lastly, the work of Laënnec is to be considered. One hesitates to begin, so great were the achievements of this one physician in the forty-five short years of his life. Laënnec, without laboratories, without guinea-pigs, without microscopes, without x-rays, observed all, heard all, and understood all. Ask any French colleague to name three giants who mark the capital stations in the progress of medicine and he will answer: Hippocrates, Laënnec, and Pasteur. It is difficult to make a list of the fifty greatest names in medical progress and if asked to name but three one cannot find too much fault in the proud answer of our French colleagues. It would have been a happy discovery simply to have invented the stethoscope alone and medical history would grant Laënnec a high place, but this genius, in the space of three short years, gave to physical diagnosis of chest diseases *all* of its terminology. He had discovered bronchiectasis, pulmonary emphysema, pulmonary edema, gangrene of the lung, acute pneumonia with its three pathological stages, pleurisy, and pneumothorax. No one added basic information to this work. When he laid down his pen the task was finished—beautifully and artistically completed. And the measure of his genius is that time and all the new methods of investigation have only confirmed his work.

Figure II


ANATOMIE

DESCRIPTIVE,

PAR

J. CRUVEILHIER,

TOME PREMIER

PARIS.

BECHET JEUNE,

1834

Figure 2. Autographed copy of "Anatomie descriptive" by J. Cruveilhier.

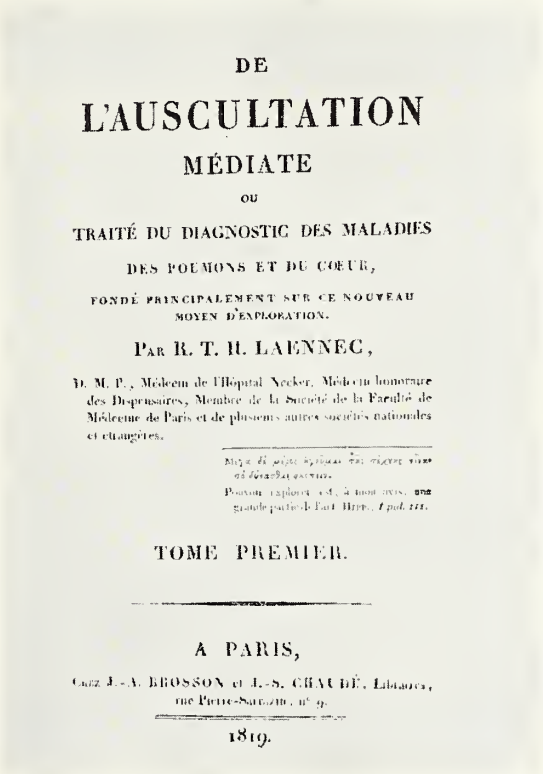
It is not necessary to recount here the facts and milestones of his short life. Most of you are already acquainted with them and all can read them. His life was a constant struggle and battle for health, for his professional education, for his private practice. He was the first and foremost physician in Paris at a time of political turmoil not unlike that of today. The political and economic dislocation at the time Napoleon was supplanted by Louis XVIII (1815) dispersed his practice and his patients. There was the struggle against the envious and jealous who wished to discredit his achievement. But if they ridiculed his invention the very same men were practicing and using his method of auscultation. Every great scientist, every great innovator has had to suffer this—it is their daily bread. His grand dignity, his humility, his patient and laborious fact-finding on the hospital ward and at the autopsy table, and above all his noble character, triumphed over all. He was one of the greatest of physicians.

During recent military service in France I spent many months at the old Hôtel-Dieu in Rouen. In one corner of the ground floor of our hospital the nuns of the Hôtel-Dieu faithfully and carefully guarded many treasures of French medicine, notably several unedited papers in Laënnec's handwriting, and his thesis[2] for the doctorate of medicine printed in June, 1804, containing many marginal notes and corrections in his own hand. He had visited Rouen often on consultations and to stay with friends. My almost daily visits to this shrine —for there were other mementos of his—developed an intense interest and fascination in this great man of our profession.

Accompanying illustrations are reproductions of the title pages of my copy of the priceless 1819

[2] *Les Propositions sur la Doctrine d'Hippocrate Relativement à la Medicine Practique* (The Propositions in the Doctrine of Hippocrates in Relation to Medical Practice). It is interesting to note that Laënnec, from his very first technical publication, placed his medical career under the aegis of Hippocrates. As a true observer of disease Laënnec now ranks beside the Father of Medicine.

Figure III-a



DE

L'AUSCULTATION

MÉDIATE

OU

TRAITÉ DU DIAGNOSTIC DES MALADIES

DES POUMONS ET DU CŒUR,

FONDÉ PRINCIPALEMENT SUR CE NOUVEAU MOYEN D'EXPLORATION.

PAR R. T. H. LAENNEC,

D. M. P., Médecin de l'Hôpital Necker, Médecin honoraire des Dispensaires, Membre de la Société de la Faculté de Médecine de Paris et de plusieurs autres sociétés nationales et étrangères.

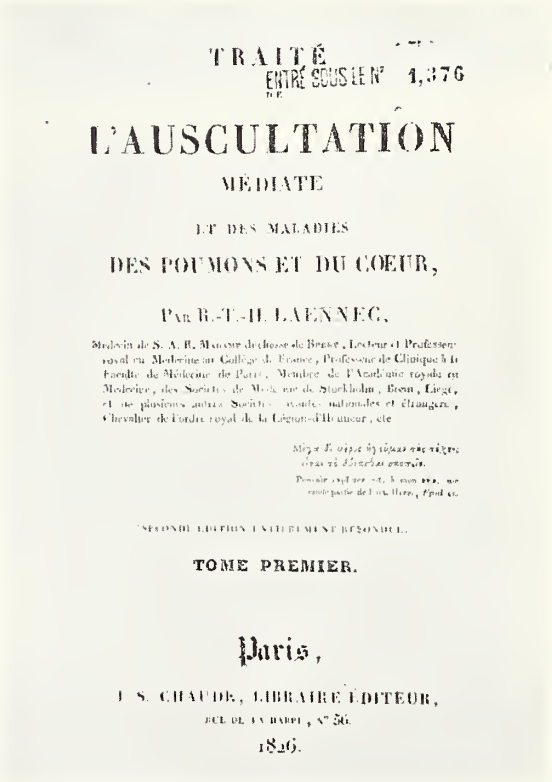
TOME PREMIER.

A PARIS,

Chez J.-A. BROSSON et J.-S. CHAUDÉ, Libraires, rue Petit-Sarazin, n° 9.

1819.

Figure III-b



TRAITÉ

ENTRÉ SOUS LE N° 1,376

L'AUSCULTATION

MÉDIATE

ET DES MALADIES

DES POUMONS ET DU CŒUR,

PAR R.-T.-H. LAENNEC,

Médecin de S. A. R. Madame duchesse de Berry, Lecteur et Professeur royal en Médecine au Collége de France, Professeur de Clinique à la Faculté de Médecine de Paris, Membre de l'Académie royale de Médecine, des Sociétés de Médecine de Stockholm, Bonn, Liége, et de plusieurs autres Sociétés savantes nationales et étrangères, Chevalier de l'Ordre royal de la Légion-d'Honneur, etc.

SECONDE ÉDITION ENTIÈREMENT REFONDUE.

TOME PREMIER.

Paris,

J. S. CHAUDÉ, LIBRAIRE-ÉDITEUR,

RUE DE LA HARPE, N° 56.

1826.

Figure 3A. Title page of the rare 1819 edition of Laennec's first treatise on "Mediate Auscultation," owned by the author.

Figure 3B. The 1826 edition prepared by Laennec shortly before his death. Entirely re-edited it covers all thoracic diseases, and in addition their treatment is discussed.

edition on *Mediate Auscultation* (the first treatise on the stethoscope), as well as his second edition of 1826 (an entirely re-arranged book), finished just a few months before he died. (Fig. 3A and 3B.)

So they pass once again before us: Bichat, Corvisart, Louis, Bayle, Bretonneau, Bouillaud, Cruveilhier, and Laënnec. Genuine physicians, courageous Frenchmen, great benefactors.

There could be no more appropriate conclusion, certainly none more appropriate to the problems and complexities of our present day, than a statement by Francois Chateaubriand, the great nineteenth centry French author. In 1819 he wrote a review of the important historical events of that year, which appeared in his *Mélanges Littéraires.* He commented upon the beautiful discovery of Laënnec with the brevity, logic, and lucidity so characteristic of the French—

"Si l'on pouvait inventer une machine pour entendre ce qui se passe dans la conscience des hommes, cela serait bien utile au temps ou nous vivons."

(If one could invent a machine to hear what goes on in the conscience of men, it would be so useful in the time in which we are living.)

COMING NEXT MONTH—MEDICAL YEAR BOOK NUMBER

The second Indiana Medical Year Book Issue, containing numerous articles on a variety of economic subjects, the Constitution and By-Laws of the Indiana State Medical Association, Principles of Medical Ethics of the American Medical Association, the membership roster of the Indiana State Medical Association and the Woman's Auxiliary, state boards, et cetera, will be the January issue of THE JOURNAL. Watch for it!

THE WORLD INFLUENZA CENTER IN LONDON

H. M. Powell, Sc.D.*

INDIANAPOLIS

DURING the latter part of July, 1947, the writer attended the Fourth International Congress for Microbiology in Copenhagen. At these meetings a group of some two dozen persons interested in the subject met one afternoon to discuss what might be done on influenza virus study in anticipation of influenza which might become pandemic. It is apparent that the present specified types A and B influenza virus vaccine would either (1) be effective or (2) scarcely at all effective, and this might depend largely on relationship of any new pandemic strains of virus to strains of virus in the vaccine. In event the latter alternative should prove to be the case, it seemed wise to plan a definite sort of world wide action which could be done well in advance of epidemic influenza but which could not be done at the eleventh hour with influenza in full swing. It was decided to request, through one of the members of this informal meeting, namely Dr. R. Gautier, of the Geneva Office of the United Nations World Health Organization, that United Nations sponsor a World Influenza Center. The two purposes would be (1) to gather and distribute without delay information about fresh outbreaks of influenza and (2) to act as a depository and exchange of influenza virus strains which might be studied antigenically, et cetera, if possible.

There was full realization that while it would be too late coincident with the local appearance of influenza to hurry isolation of new, possibly mutant strains of virus, and incorporate these into vaccine on a large scale, however if influenza should spread from country to country or from hemisphere to hemisphere, newly isolated strains in local epidemics could be sent rapidly by air to non-influenza areas of the world for rapid intensive study. Only in event these proved dissimilar to vaccine strains would they need to be used in further vaccine production.

The writer has received a communication from Dr. R. Gautier, dated September 15, from Geneva, Switzerland, to the effect that the interim commission of the World Health Organization has decided to allocate $3,000 for financing a beginning World Influenza Center in London. An accompanying note by Dr. C. H. Andrewes of the National Institute of Medical Research, Hampstead, London, and who will organize the Center, sets forth the lines of activity which the Center will pursue. Some of the difficulties are cited, however Dr. Andrewes states the difficulties should not be insuperable.

The World Influenza Center would (1) collect and distribute information about incipient influenza epidemics, (2) collect and exchange pathological material, viruses, diagnostic material, and (3) train a few laboratory workers from time to time in standard methods of influenza virus work. Local "listening posts" would be Regional Laboratories, and while these might be situated in close connections with ministries of health, it is suggested that exchange of information would be more rapid if it came direct from observers and not through other official channels.

Establishment of this influenza center seems to the writer to be highly worth-while in view of the great mortality caused by the 1918 influenza pandemic. It is hoped that the present vaccine, which contains A and B types of both classic and recently isolated strains of virus, will be effective. It is prescribed, licensed, and tested by the National Institute of Health of the United States Public Health Service. In view, however, of the newer knowledge about mutation and change in viruses possibly anything could happen in connection with pandemic influenza. Although the bacterial secondary invaders accompanying influenza seem well controlled by antibiotics and sulfonamides, it is not impossible that resistant bacteria might also appear.

Establishment of The World Influenza Center comprises one step in the direction of doing a few simple things which many persons have thought about, and most all would think about when it might become too little and too late. It seems appropriate that Dr. C. H. Andrewes, of the Smith, Andrewes, and Laidlaw authorship of the classical 1933 work on epidemic influenza virus, should start the World Influenza Center.

* Lilly Research Laboratories.

Medical Panorama by the Associate Editor

OHIO deplores the manner in which many local health department reports are made. They call them "dreary documents," packed with figures, charts, and unintelligible material, so far as the public is concerned. A suggestion is made that an excellent field of public relations is being neglected. A contrasting report of conditions 10, 20, 40 years ago, made in an interesting, understandable manner "would inspire public confidence and support."

———S I M A———

JACKSON COUNTY (Missouri) may well be proud of the success of their Jackson County Health Forum. For several years they have sponsored the activities of a group of forward-looking women who have been responsible for providing educational programs on medical matters that serve to promote a better understanding between physicians and the public. Started several years ago, their Lecture Series now enjoy national recognition. Such an activity might well be emulated by many medical societies.

———S I M A———

DALLAS Medical Journal reproduces portions of two prescriptions recently presented to druggists for filling. Because of illegibility several pharmacists refused to attempt to fill them. Indicating these examples of turkey tracks as a definite menace to public health, the plea is made that more consideration be given the pharmacists who have to decipher the writing, as well as the patient who may be forced to take them from one drug store to another in attempting to have them filled. The courtesy of druggists, in calling physicians for interpretation of a prescription, should be received with an equally courteous response and appreciation.

———S I M A———

NORTHWEST MEDICINE, in a plea for the entire profession to interest itself and work for the common concern of medical practice, decries the tendency of so many members to sneer at the efforts of fellow practitioners who assume more than their share of responsibility and sacrifice in order to preserve medical organization and to solve the many problems confronting us. Commonly referred to as "medical politicians," they are, in reality, the unselfish workers of the profession without whom the slackers might well be without many of their privileges.

METROPOLITAN Life Insurance Company's Bulletin reports on "Longevity and Mortality of American Physicians." At 25 there is a life expectancy of 43½ years. At 35 about 35 more years. At 45 an additional 25 years. At 65 almost 12 years more.

———S I M A———

OHIO quotes from an article by Dr. Frank Lahey in the Lahey Clinic Bulletin as follows:

"I do not believe that nurses need the amount of medical instruction that they now receive under the present nurse teaching curriculum.

"I believe that many nurses not only will never use some of it, but do not comprehend some of it.

"I believe that too much of the nurses' time is spent away from the bedside and that much of the doctors' time in teaching them is in some measure wasted.

"I believe that two years of high school education is an adequate amount of education for a service nurse to have in order to comprehend the basic principles of service nursing and I believe by this plan more nurses, so badly needed, will be obtained.

"I believe that four years of high school is an adequate preliminary education for any nurse.

"I believe that there should be two types of nurse education, one for the service nurse and one for the nurse educator.

"I believe that the motif of nursing which once was so strongly stressed, personal service, is being lost and should be regained.

"I believe that opportunities should be opened for nurses trained for service nursing to continue on to further advanced nursing education if their interests and aptitude indicate justification, irrespective of their degree of preliminary education. A lack of fundamental education can be and has been compensated for in medicine by application and aptitude and can be in nursing.

"I believe that any hospital which does not have an adequate number of nurses or an adequate number immediately in prospect is failing to meet its obligations to a bed situation now acute and not improving if it is not attempting to increase its nursing personnel by organizing a service nursing program or something comparable with it.

"I believe a program should be established as soon as possible jointly by the American Medical Association, American Hospital Association, American Nursing Association, The American Association of Medical Colleges, and the Catholic Hospital Association on what is the proper requirement for the training of a service nurse, and that until this is done no progress will be made."

What's Going On In Indiana by the Executive Secretary

The 1948 and 1949 Annual Sessions. Indianapolis was chosen by the House of Delegates as the place for the 1948 and 1949 state meetings. The dates for the 1948 session are Tuesday, Wednesday, and Thursday, October 26, 27, and 28. The Indianapolis Convention and Publicity Bureau has assured the association that no other convention will be booked for these three days and fifteen hundred good hotel rooms will be available. Now that the dates are set, our members can write for hotel rooms—and it isn't a bad idea to do it now. The 1949 meeting will be our centennial, and planning for it began several years ago. Some physicians have expressed the wish that our annual sessions be held earlier in the autumn. This would be desirable if conflicts did not occur with other state and national medical meetings, virtually forcing the I.S.M.A. into the last week of October.

——ISMA——

Hotel Rooms at French Lick. The French Lick Springs Hotel management accepted fifty-six more reservations for the 1947 state session than could be accommodated, expecting the normal 10 per cent cancellation. But the cancellations did not develop and two days before the meeting the hotel had more people to house than its capacity. Manager Kelley telegraphed fifty-six doctors who had confirmed reservations, telling them he could not accommodate them. At the last minute, however, some doctors did cancel their rooms and thirty-two of the fifty-six finally received rooms. Unfortunately, approximately forty physicians who had made reservations neither showed up nor notified the hotel they wouldn't be there. As a result, twenty-four doctors who wanted reservations and were refused did not get to the session and the hotel ended up with vacant rooms. Manager Kelley has written the forty doctors who failed to use or cancel their rooms, pointing out the regrettable situation.

——ISMA——

Nursing School Requirements. The Committee on Medical and Nursing School Scholarships has joined hands with the Indiana State Nurses' Association in preparing an attractive booklet on entrance requirements for the accredited schools of nursing in Indiana. These booklets are being circulated among the principals, deans and student advisors of the state's high schools. In the booklets may be found the subjects which girls should take in high school to admit them to the nursing school of their choice. As far as it is known, this is the first time this data has been assembled and made available to high school pupils. It is expected to be an important factor in interesting more girls in nursing. The Council voted $300 to help finance the printing of the booklets, and the state nurses association and some of the hospitals have supplied funds. The nursing association collected the information, receiving splendid co-operation from the twenty-seven nursing training schools. It is a joint effort which is worth-while.

——ISMA——

Prepayment Medical Care News. Upon learning what had been done by the Michigan State Medical Society in its prepayment medical care insurance company, Senator Vandenberg was pleasantly surprised, and admonished the society officers to let more people know about it. One out of every four persons in Michigan is covered with some prepayment medical care insurance, proving to doubting Thomases that if given the opportunity voluntary medical care will work and make compulsory health insurance, as embodied in the Wagner-Murray-Dingell bill, unnecessary. Mutual Medical Insurance, Inc., Indiana medicine's prepayment medical care company, is making rapid strides, with well over a hundred thousand certificate holders at the end of the first year. As of September 30, 1947, 6,823,393 persons were enrolled in some medical prepayment plan in the United States, Canada, Hawaii, and Puerto Rico. In the United States, Canada, and Puerto Rico, on July 1, 1947, 28,330,166 persons were covered by Blue Cross hospital service. These figures send cold shivers down the spines of the Wagner-Murray-Dingell proponents who have said that private initiative can't provide medical and hospital care . . . that only the federal government can do it.

—ISMA—

Association Will Sponsor Bill. The House of Delegates voted at French Lick to sponsor a bill in the 1949 Indiana legislature which would make it unlawful for any person to use the prefix "Doctor" before his name unless it had been conferred upon him by a recognized educational institution, and an abbreviation is also used as a suffix to designate the nature of the degree. In other words, each doctor of medicine would have to use "M.D." after his name, each dentist would be compelled to use "D.D.S.," et cetera. This kind of a law would make it possible for the laity to distinguish between the various doctors, particularly those practicing the healing arts. Unquestionably many persons go to "doctors" for treatment who are not M.D.'s, thinking that they hold Doctor of Medicine degrees. The law would eliminate this confusion. It would seem that nobody could object unless it would be the "doctors" who are capitalizing upon the title. Missouri passed such a law two years ago and it has proved very satisfactory.

THE JOURNAL
OF THE
Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Anatomy, Concise (Edwards) The Blakiston Company ---------- 1066
Birth, The Story of Human (Guttmacher) Penquin Books, Inc. ---------- 552
Chemistry, Practical Physiological (Twelfth Edition) (Hawk) The Blakiston Company ---------- 552
Chest. A Handbook of Roentgen Diagnosis, The (Rigler) The Year Book Publishers, Inc. ---------- 552
Chest: With Emphasis on X-ray Diagnosis, Diseases of the (Rugin) The W. B. Saunders Company ---------- 782
Ego and the Mechanisms of Defense, The (Freud) International Universities Press ---------- 552
Eye, May's Manual of the Diseases of the (Perera) Williams & Wilkins Company ---------- 1066
Eye, Office Treatment of the (Selinger) The Year Book Publishers, Inc. ---------- 1066
Folic Acid, Experiences With (Spies) The Year Book Publishers, Inc. ---------- 692
(Geriatrics) The Care of the Aged (Thewlis) (r) C. V. Mosby Company ---------- 464
Gynaecology, One Hundred Years of (Ricci) (r) The Blakiston Company ---------- 930
Gynecology, Essentials of (Cooke) (r) J. B. Lippincott Company ---------- 930
Gynecology (With a Section on Female Urology) (Second Edition) (Wharton) W. B. Saunders Company ---------- 782
Hygiene (Meredith) (r) The Blakiston Company ---------- 552
Hypertension, Its Diagnosis and Treatment, Arterial (Page, Corcoran) (r) The Year Book Publishers, Inc. ---------- 782
Immunology (Including Allergy) Office (Sulzberger, Baer) The Year Book Publishers, Inc. ---------- 1066
Labor, the Puerperium and the Newborn, A Textbook on Pathology of (McCormick) (r) C. V. Mosby Company ---------- 1066
Marriage and Divorce, Unhappy (Bergler) (r) International Universities Press ---------- 930
Medical Dictionary (21st Edition), The American Illustrated (Dorland) W. B. Saunders Company ---------- 1066
Medicine, A Textbook of (Cecil) W. B. Saunders Company ---------- 782
Medicine in General Practice, Internal (Second Edition) (McCombs) W. B. Saunders Company ---------- 1066
Medicine, Synopsis of (Tidy) (r) Williams & Wilkins Company ---------- 930
Metabolism—Detailed Methods of Diagnosis and Treatment—A Text for the Practitioner, Diseases of (Duncan) W. B. Saunders Company ---------- 782
Neurology, Fundamentals of Clinical (Merritt, Mettler, and Putnam) (r) Blakiston Company ---------- 930
Newborn, A Textbook on Pathology of Labor, the Puerperium and the (McCormick) (r) C. V. Mosby Company ---------- 1066
Nutrition (Fourth Edition), Infant (Jeans and Marriott) The C. V. Mosby Company ---------- 1066
Nutritional and Vitamin Therapy in General Practice (Gordon) The Year Book Publishers, Inc. ---------- 782
Obstetrical Practice (Beck) The Williams & Wilkins Company ---------- 692
Pathology, Surgical (Boy) W. B. Saunders Company ---------- 782
Plague, The Unconquered (A Popular Story of Gonorrhea) (Wain) International Universities Press ---------- 692
Psychiatry, Fundamentals of (Fourth Edition) (Strecker) J. B. Lippincott Company ---------- 1066
Psychoanalysis, The Yearbook of (Volume II) Editorial Board, International Universities Press) International Universities Press ---------- 552
Psychoanalytic Study of the Child, The (Volume II) (International Universities Press) International Universities Press ---------- 782
Puerperium and the Newborn, A Textbook on Pathology of Labor, the (McCormick) (r) The C. V. Mosby Company ---------- 1066
Radiology for the Medical Student (Hodges) The Year Book Publishers, Inc. ---------- 552
Rh Factor, The (Potter) The Year Book Publishers, Inc. ---------- 782
Roentgen Diagnosis, The Chest. A Handbook of (Rigler) The Year Book Publishers ---------- 552
Surgery of the Ambulatory Patient (Second Edition) (Ferguson) J. B. Lippincott Company ---------- 1066

Symptoms, The Analysis and Interpretation of (MacBryde) (r) J. B. Lippincott Company 930
Urology, Gynecology with a Section on Female (Second Edition) (Wharton) W. B. Saunders Company 782
Vitamin Therapy in General Practice, Nutritional and (Gordon) The Year Book Publishers, Inc. 782
X-ray Diagnosis, Diseases of the Chest: With Emphasis on (Rugin) W. B. Saunders Company 782

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News Notes

Announcement has been made by Dr. Maurice A. Turner, formerly of Huntingburg, of the opening of an office in Oakland City, for the practice of medicine.

Dr. James M. Wilson, formerly of Rochester, Minnesota, has opened an office in the J. M. S. building, in South Bend, where he will practice general surgery.

Dr. and Mrs. Robert W. Vermilya, formerly of Waveland, have moved to Alexander, Virginia, where the doctor will study anesthesia.

Miss Rose Mary Rafferty, of Indianapolis, daughter of Mr. and Mrs. John M. Rafferty, of Star City, and Dr. Martin A. Seidell, son of Mr. and Mrs. Frederick M. Seidell, of Indianapolis, were married on October nineteenth, in the St. Ann's Church, in Kewanna. Dr. Seidell is a graduate of the Indiana University School of Medicine.

Dr. Oliver B. Beardsley has left South Bend to become a medical missionary in a leper colony at Mwami station, Northern Rhodesia, Africa.

Dr. Lloyd Bridges, who was recently discharged from the Army, has announced the opening of an office in Markleville for the general practice of medicine.

Announcement has been made that Dr. James M. Davis, who has recently been discharged from the Army, has become associated with Dr. George Love, in Connersville, in the practice of medicine and surgery.

The Indiana University School of Medicine and Medical Center were the setting for the 35th annual meeting of the Clinical Orthopedic Society, October 24-25. Sessions brought more than 250 leaders in this field to the campus from the entire midwest. More than 200 cases were presented during the meeting. Dr. George J. Garceau, of Indianapolis, has been elected president.

Dr. Lloyd H. Goad, who has recently returned from eighteen months' refresher work at the Denver General Hospital, in Colorado, is now associated with Dr. A. A. Watts, of Gary, in the practice of medicine. Dr. Goad is a veteran of World War II, having spent more than three years in a Jap prison camp. He was discharged from the Army in May, 1946, having attained the rank of major.

Dr. C. Robert Plank has joined the staff of St. Anthony's Hospital, in Michigan City, as a radiologist.

Dr. Donald S. Painter has left Cromwell to accept a residency in obstetrics at the Methodist Hospital, in Indianapolis. Dr. Edward J. Ettl, formerly of Elkhart, has moved to Cromwell, where he will practice medicine.

Announcement has been made by Dr. Cecil G. McEachern of the opening of an office at 702 Wayne Pharmacal Building, in Fort Wayne. He will be associated with Dr. D. F. Cameron, and his practice will be limited to surgery.

Dr. E. K. Mosny, formerly of St. Charles, Illinois, is now associated with the Whitlatch Clinic and Hospital, in Milan.

Dr. Burton E. Kintner, of Elkhart, has been appointed Elkhart County coroner, to fill the unexpired term of Dr. S. C. Wagner, of Elkhart, who has resigned.

Dr. Arvin Henderson, Jr., has left Ridgeville for New York where he will be connected with the New York university hospital, specializing in pediatrics.

Dr. Fred Houston, formerly of Indianapolis, has opened an office in the Purity Sweets Building, Lawrenceburg, for the practice of general medicine. Dr. Houston is a veteran of World War II, serving in the Army Medical Corps, where he attained the rank of captain.

Dr. Grant Johnson, formerly with the Walter Reed Hospital, in Washington, D.C., has opened an office in Etna Green for the practice of general medicine.

Dr. Donald W. Mason, a veteran of World War II, recently became affiliated with the Cameron hospital in Angola.

Dr. Homer R. Swihart has announced his association with Dr. Claude F. Fleming, 121 West Marion Street, Elkhart. Doctor Swihart is a veteran of World War II, having entered the army in October, 1945. He served eighteen months overseas in Korea and Tokyo. He was separated from the army on September 9, 1947.

Miss Vera Morris, daughter of Mrs. George F. Morris, of Peru, and Dr. Joseph L. West, son of Mrs. Frank L. West, of Indianapolis, were united in marriage on October sixteenth, in the St. Joan of Arc Church, in Indianapolis. Dr. West is a recent graduate from the Indiana University School of Medicine.

Dr. Thad T. Richardson, who has recently served his internship at the Indianapolis City Hospital, has left for Randolph Field, Texas, where he will go into training as flight surgeon in the Air Corps.

Dr. Hugh A. Miller, Jr., who was discharged in January, 1946, after five years of service as a naval medical officer, has returned to Elkhart and will share offices with Dr. James A. Work, Jr., and Dr. David D. Todd, at 414 South Second Street. Doctor Miller will engage in the practice of general medicine.

Dr. Solomon V. Panares, of Hammond, was selected to make an airplane trip around the world for medical research with a committee of doctors from all sections of the United States. Doctor Panares, who was a captain in the army medical corps during World War II and served nearly three years at station hospitals on the battlefields of France, will make a study of tropical diseases, while in the Pacific.

The National Jewish Hospital at Denver announces a program of Fellowships for postgraduate study in tuberculosis and allied diseases. Fellows will be appointed for three-month, six-month, or one-year periods. Information regarding the Fellowships can be obtained by writing to Dr. Edgar Mayer, Chairman, National Medical Advisory Board, National Jewish Hospital at Denver, 470 Park Avenue, New York, N. Y. or to Dr. Allan Hurst, Medical Director, National Jewish Hospital at Denver, 3800 East Colfax Avenue, Denver 6, Colorado.

Notice of Liquidation of Midwestern Agricultural Workers' Health Association, Inc.

Notice has been given that the Midwestern Agricultural Workers' Health Association will not provide services for foreign agricultural workers after December 31, 1947. Any outstanding authorizations or bills payable by the Association should be submitted for payment very promptly. It is not expected that payments can be made from Health Association funds after January 31, 1948. This situation is brought about by the liquidation of the Labor Branch program.

St. Francis Hospital, Beech Grove, has been approved for general residencies by the American Medical Association.

Nineteen more physicians who have been in practice for fifty years or more have been added to the roster of the "Fifty Year Club." Their names were received too late to include in the November issue of THE JOURNAL.

They are Dr. Dulania S. Wiggins of New Castle, Dr. Joseph F. Gillespie of Greencastle, Dr. John W. Henry Ranke of Fort Wayne, Dr. James R. King of Silver Lake, Dr. James E. Keeling of Waldron, Dr. John F. Take of French Lick, Dr. Emery G. Bounell of Hillsboro, Dr. James W. Benham and Dr. Lotta A. Suverkrup, both of Columbus, Dr. William A. Hodges, Oaktown, Dr. Jessie C. Calvin, Fort Wayne, Dr. Henry Nenneker, Evansville, Dr. Rodney D. Smith, Bloomington, Dr. Murray M. Sears, Elkhart, Dr. Freeman E. Keith, St. Bernice, Dr. Vernon C. Patten, Morristown, Dr. Samuel W. Boren, Poseyville, Dr. Edward F. Tindal, Muncie, and Dr. A. M. Kirkpatrick, Columbus.

Indianapolis Obstetrical and Gynecological Society Meeting

Dr. J. P. Greenhill, author of the Greenhill-De Lee obstetric textbook and the Yearbook of Obstetrics and Gynecology, will address the Indianapolis Obstetrical and Gynecological Society Wednesday evening, January 14, 1948, at its first annual meeting. His subject will be "Pelvic Pain in Women—Both Obstetric and Gynecologic." The meeting is to be a dinner-guest affair at the Indianapolis Athletic Club, 6:30 P.M., and will be open to all interested physicians. The reservations, $5.00 each, are to be made through the office of Dr. Lawson J. Clark, Secretary, 420 Hume Mansur Building, not later than January tenth.

Eighth Annual Congress on Industrial Health

The Council on Industrial Health will hold its Eighth Annual Congress on Industrial Health in the Cleveland Auditorium, Cleveland, on January 5 and 6, 1948. These dates immediately precede the Interim Session of the American Medical Association, which will be held in the Auditorium on January 7 and 8. General practitioners supply a large part of the medical services which workers receive through industry, and they are invited to attend these industrial health sessions. The program of the Congress is being constructed with general practitioners in mind and will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation.

1948 Annual Session of the American College of Physicians

The American College of Physicians will conduct its 29th Annual Session at San Francisco, April 19-23, 1948. General Headquarters will be at the Civic Auditorium. Dr. William J. Kerr and Dr. Ernest H. Falconer, both of San Francisco, are the co-chairmen for local arrangements and the program of clinics and panel discussions. The president of the college, Dr. Hugh J. Morgan, Professor of Medicine at Vanderbilt University School of Medicine, Nashville, Tennessee, is in charge of the program of Morning Lectures and afternoon General Sessions.

American Academy of General Practice

Dr. Lester D. Bibler, of Indianapolis, who is a member of the board of directors of the American Academy of General Practice, reports that the academy is showing phenomenal growth. Mr. Mac Cahal recently has been employed as executive secretary of the academy. At a directors meeting, held recently in Chicago, it was announced that the American Academy of General Practice of Wayne County (Detroit) Michigan, and the American College of Physicians and Surgeons of Minnesota and Illinois have affiliated with the A.A.G.P. Doctor Bibler urges all general practitioners to become affiliated with the organization while membership still is available. The founders group will close in December.

Announcement of Van Meter Prize Award

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Toronto, Canada, May 6th, 7th, 8th, 1948, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than February 1st, 1948. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

Following his recent discharge from the Army Medical Corps, Dr. Gaylor W. Stalter has opened an office in North Webster, for the practice of medicine.

Dr. Philip W. Rothrock has opened an office for the practice of medicine at 1625 Kossuth Street, in Lafayette, after completing a residency in Internal Medicine at the Indiana University Medical Center.

Physicians Invited to Cleveland Meetings

Two meetings of interest to Indiana physicians will be held at Cleveland, Ohio, early in January in conjunction with the supplementary session of the House of Delegates of the American Medical Association.

The first will be the Mid-West Regional Conference sponsored by the Council of Medical Service of the A.M.A., of which Thomas A. Hendricks, former I.S.M.A. executive secretary, is secretary, on Sunday, January 4, in the Cleveland hotel. The program will begin at 10 o'clock in the morning and continue throughout the day. Subjects to be discussed include services offered by the A.M.A. headquarters, public relations, rural medical care, federal health legislation, and prepayment medical service insurance.

The mid-west region embraces Indiana, Ohio, Illinois, Kentucky, Michigan, and West Virginia. All physicians are invited to the conference.

Monday and Tuesday, January 5 and 6, will be devoted to meetings of the A.M.A. House of Delegates. Indiana State Medical Association delegates are Dr. H. G. Hamer of Indianapolis, Dr. F. S. Crockett of Lafayette, Dr. A. S. Giordano of South Bend, and Dr. W. M. Cockrum of Evansville.

The second "Grass Roots" conference for officers of county medical societies will be held Tuesday night, January 6, with Dr. A. M. Mitchell of Terre Haute serving again as chairman. The first such meeting was held in Atlantic City last June, and because of its success, the conference was arranged for Cleveland, and will become an annual event of the A.M.A. winter session.

Scientific programs, including exhibits, have been scheduled for Wednesday and Thursday, January 7 and 8. This scientific session will be devoted to subjects of prime interest to general practitioners. Since the annual summer session of the A.M.A. has grown so large that few cities can house the meeting, the winter scientific program was established in the hope that many doctors would attend it instead, and lessen attendance at the summer session.

The annual Conference on Rural Medical Service will be held in Chicago on Friday and Saturday, February 6 and 7, 1948, with the National Conference on Medical Service following on Sunday, February 8.

Dr. Donald A. Covalt, chief of Veterans Administration physical medicine rehabilitation service, resigned November 15, to become associate professor of physical medicine and rehabilitation in the New York University School of Medicine and also head of NYU's new Rehabilitation Institute, Dr. Paul R. Hawley, VA medical director, announced recently.

Dr. A. Ray Dawson, for the past year and a half head of the physical medicine rehabilitation service in the Richmond, Virginia, Branch Office of VA, has been named to succeed Dr. Covalt.

Dr. Covalt is a native of Muncie, and a graduate of Indiana University Medical School. He practiced in Muncie for about nine years. He joined VA in 1945 after serving as chief of rehabilitation for the Air Corps. He is a recognized leader in the field of physical medicine and rehabilitation and was in charge of establishing medical rehabilitation units in VA's 126 hospitals. As head of NYU's Rehabilitation Institute, one of the first of its kind in the country, Dr. Covalt will have an opportunity to extend his wide experience in the rehabilitation field to the civilian population.

American Board of Obstetrics and Gynecology, Inc.

The next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 6, 1948, at 2:00 P. M. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year.

A number of changes in Board regulations and requirements were put into effect at the last annual meeting of the Board held in Pittsburgh, Pennsylvania, from June 1, to June 7, 1947. Among these is the new ruling that the Board does not subscribe to any hospital or medical school rule that certification is to be required for medical appointments in ranks lower than Chief or Senior Staff of hospitals, or Associate Professorship in Schools of Medicine, for the obvious reason that such appointments constitute desirable specialist training. At this meeting the board also ruled that credit for graduate courses in the basic sciences which involve laboratory and didactic teaching rather than clinical experience or opportunities will be given credit for the time spent up to a maximum period of not more than six months regardless of the duration of the course.

Applications are now being received for the 1948 examinations. Closing date for these applications will be November 1, 1947.

For further information and application blanks address Paul Titus, M.D., Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Dr. Kenneth L. Craft, of Indianapolis, was elected vice-president of the American Society of Opthalmological and Otolaryngological Allergists at the annual meeting of the society in October. Doctor Craft addressed the society upon "Nasal Surgery in the Allergic Patient" at that meeting.

Dr. Joseph L. Haymond has announced the opening of an office and medical laboratory at 605 East Thirty-eighth Street, Indianapolis. Doctor Haymond's practice is limited to clinical pathology For the past five years he has been associate pathologist at the South Bend Medical Foundation.

Dr. M. E. Frantz, a practicing physician and surgeon in Danville for ten years, has resumed practice there after returning from service with the Army Air Corps since August, 1943. Doctor Frantz was with the Flying Tigers in China, India, and Burma. He was a lieutenant-colonel at the time of discharge.

INDIANA UNIVERSITY NEWS NOTES

Inauguration of a postgraduate course for physicians of the Vanderburgh county area, as a joint undertaking of the Indiana University School of Medicine and the Vanderburgh County Medical Society, has been approved by the Council of the medical school. The new program, designed to begin in January with a series of study meetings on a specific topic, will be followed by the appearance of staff members from the medical school to conduct a seminar on the study topic. In the series of monthly seminars a wide range of subjects of interest to the medical profession will be covered. Dr. John D. VanNuys, dean of the medical school, expects the Evansville program to be the forerunner of a series of such medical extension programs through which the school can offer postgraduate work to the physicians of the state.

Suggestions of Hoosier physicians on the subject matter to be presented at a postgraduate course, scheduled by the Indiana University School of Medicine during the latter part of May and early June, are being sought by the school's Committee of Postgraduate Instruction. It is the committee's desire to include the material which the physicians themselves feel would be of the most value to them in their regular practice. Suggestions should be addressed to: Dr. John J. Mahoney, assistant to the Dean, Indiana University School of Medicine, 1040 West Michigan street, Indianapolis 7.

Deaths

Joseph C. Clawson, M.D., of Richmond, died on October seventh in Tampa, Florida, following a few weeks' illness. Doctor Clawson was seventy-one years of age. He was graduated from the Illinois Medical College, in Chicago, in 1905, and had practiced medicine in the community of Richmond for forty years, retiring about a year ago. Doctor Clawson was a member of the Wayne-Union County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Ross Alvah Cooper, M.D., of Carmel, died on November ninth, following a brief illness. He was sixty-five years of age. Doctor Cooper graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906 and for thirty-eight years had been a practicing physician in the community of Carmel. He was a veteran of World War I. Doctor Cooper was a member of the Hamilton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Donald Lee Colglazier, M.D., of Indianapolis, died at his home on October sixteenth, at the age of forty-seven years. Doctor Colglazier was graduated from the Indiana University School of Medicine, in Indianapolis, in 1930. He was a veteran of World War II, having served as a captain in the Army Medical Corps. Doctor Colglazier was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Harry S. Hicks, M.D., of Hammond, died on October thirtieth at the age of sixty-nine years. Doctor Hicks was graduated from the Medical College of Indiana, in Indianapolis, in 1901. He was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

E. Oscar Lindenmuth, M.D., of Indianapolis, died on October twentieth, following an illness of several weeks. He was seventy-five years of age. Doctor Lindenmuth was graduated from the Medico-Chirurgical College of Philadelphia, in 1906. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Joel Whitaker, M.D., of Indianapolis, died on October thirteenth, at the age of seventy-seven years. Doctor Whitaker was graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons, in Baltimore, in 1900. He had limited his practice to ophthalmology.

Michael F. Dean, M.D., of Indianapolis, died suddenly on November third. He was sixty-seven years of age. Doctor Dean was graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1907. He had been a practicing physician in Indianapolis for forty years. Doctor Dean was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Minnetta C. Flinn-Jordan, M.D., of Wabash, died on September twenty-fifth, at the age of seventy-nine years. She was graduated from the University of Michigan Homeopathic Medical School, at Ann Arbor, in 1905, and had been practicing in Wabash since 1907. Doctor Flinn-Jordan was a member of the Wabash County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Dillon J. Kennington, M.D., of Michigan City, died suddenly on November second. He was thirty-five years of age. Doctor Kennington was graduated from the Indiana University School of Medicine, in Indianapolis, in 1937. He was a member of the LaPorte County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

James A. Long, M.D., of Anderson, died on November eighth at the home of his daughter in Oxford, Ohio. He was eighty-eight years of age. Doctor Long was a graduate of the University of Louisville School of Medicine, in Louisville, in 1892 and had practiced medicine in the community of Anderson for fifty years. He was an honorary member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Ernest E. Schriefer, M.D., of Cannelton, died on November third following a brief illness. He was sixty-seven years of age. Doctor Schriefer was a graduate of the University of Louisville School of Medicine, in Louisville, in 1906. He was a member of the Perry County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Albert C. Chenoweth, M.D., of Huntington, died on October seventh, at his home, after a few weeks' illness. He was seventy years of age. Doctor Chenoweth was graduated from the Hahnemann Medical College and Hospital, in Chicago, in 1908. He had practiced in Andrews, Bluffton, and Huntington before his retirement four years ago.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

(French Lick Session, 1947)

First Meeting

The first meeting of the Council was held in the Blue Room of the French Lick Springs Hotel, at 12:30 p.m., Tuesday, October 28, 1947, the chairman, Dr. Alfred Ellison, presiding.

Roll called showed the following members present:

Councilors:
First District—I. C. Barclay, Evansville
Second District—James H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Fourth District—Not represented
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Not represented
Tenth District—W. H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—Paul A. Garber, South Whitley
Thirteenth District—Alfred Ellison, South Bend

Councilor-elect:
First District—Herman T. Combs, Evansville

Officers:
Floyd T. Romberger, Lafayette, president
Cleon A. Nafe, Indianapolis, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
N. K. Forster, Hammond, associate editor of THE JOURNAL

Members of Executive Committee:
C. H. McCaskey, Indianapolis, chairman
W. L. Portteus, Franklin
Albert Stump, Indianapolis, attorney
Ray E. Smith, executive secretary

President-elect, American Medical Association:
R. L. Sensenich, South Bend

Delegates to the A.M.A.:
Don F. Cameron, Fort Wayne
F. S. Crockett, Lafayette

General Arrangements Co-chairmen:
A. P. Hauss, New Albany
C. E. Boyd, West Baden Springs

Legislative Committee:
Norman M. Beatty, Indianapolis } co-chairmen
J. William Wright, Indianapolis }

State Board of Health:
L. E. Burney, Indianapolis, director

State Board of Medical Registration and Examination:
Paul Tindall, Shelbyville, secretary
Ruth Kirk, Indianapolis, executive secretary

The chairman read a letter received from Dr. Samuel Kennedy, Shelbyville, in which he said, "I am very sorry to tell you that I shall not be able to attend the meeting of the Indiana State Medical Association in French Lick next week. For many years I did not miss a meeting of this Association and very much regret to miss this one. I have to be in New York City all of next week. Please give everybody my kindest regards and especially the Council, of which I was a member for many years, and Dr. Roscoe Sensenich."

Upon the motion of Dr. Mitchell, duly seconded, the minutes of the July 20, 1947, Council meeting, held in Indianapolis, were approved as printed in the September, 1947, issue of THE JOURNAL.

No additions to or comments were made on the formal councilor reports which were published in the October JOURNAL.

District meetings were reported scheduled as follows:

Fifth District—May __, Greencastle
Seventh District—December 9, Martinsville
Ninth District—May 13, Frankfort
Eleventh District—May 19, Wabash
Thirteenth District—November 12, South Bend

Unfinished Business

1. *Convention arrangements.* Dr. Hauss reported that his committee had done the best it could to house the Indiana State Medical Association, this being the first time in the history of the association that the entire French Lick Springs Hotel had been turned over to the association.

The chairman of the Council, on behalf of the Council, thanked Dr. Hauss and his committee for their efforts and the outstanding job they had done.

2. *Report of Committee on Medical and Nursing School Scholarships.* Dr. Clark, chairman, reported that four medical school and eight nursing school scholarships had been awarded. Two of the nursing school scholarships were made possible by an Indianapolis citizen. He suggested that if each councilor would contact certain influential persons in his own area, he would be successful in getting additional medical and nursing scholarships. "I feel this is a bit of strategic public relations business. We probably can interest certain industrial firms in this endeavor."

Dr. Forster endorsed Dr. Clark's suggestion, saying, "Kentucky has succeeded in getting $150,000 in scholarships for medical students. They have done this simply by going to different people and telling them about the situation, the shortage of medical men in rural communities. So far as I know, they haven't included nurses, but as you all know, there is this acute shortage of nurses. If each of you will take this back to your own councilor districts, I am sure it would be a great help in putting over the medical and nursing scholarship fund."

Dr. Clark presented the following motion: "The Scholarship Committee moves that the money placed in the trust fund, if not expended for scholarships in the year for which it was appropriated, be carried over from one year to the next year so that it will be available for use by the committee." (Motion seconded by Dr. Kennedy, and carried.)

3. *Report of Committee on Study of Undergraduate Medical Education.* Dr. Hauss, chairman, read the following report:

(See House of Delegates minutes, page 1285.)

Following discussion by Drs. Hauss, Clark and Nafe concerning that part of the resolution authorizing "the appointment by the President of a Permanent Study Committee on Undergraduate Medical Education to make a detailed and permanent study of the numerous problems in this field," Dr. Hauss moved that the resolution be changed to read that "at the discretion of the president this work be assigned to a special committee or to one of the standing committees." (Motion seconded by Dr. Clark, and carried.)

4. *Medical ethics.* The following resolution, proposed by the Executive Committee, with the thought that it might be a good idea to have some sort of a committee from a higher level than the county level to review reported abuses, because of the closeness of relationship of the offenders to the county society, was referred to the House of Delegates on motion of Drs. Garber and Mitchell:

WHEREAS, Small county hospitals are increasing in number; and

WHEREAS, Inadequate pathological service is likely to be the rule; and

WHEREAS, Increasing participation in prepayment insurance plans will increase hospitalization and surgery; and

WHEREAS, These above factors will tend to increase unnecessary hospitalization and surgery; and

WHEREAS, Local hospitals and county societies may not be able or willing to control these unnecessary practices which are a detriment to the profession at large;

BE IT RESOLVED, (1) That a special committee be appointed by the president, on advice of the Council, to investigate and reprimand offenders who are guilty of such practices; (2) That these procedures be of a secret nature unless such offender or offenders refuse to co-operate in the interests of the profession at large, and (3) That the constitution be so amended to make this committee possible.

New Business

1. *Hospital licensing program.* DR. L. E. BURNEY, state health commissioner, spoke of the hospital licensing program, inaugurated following the 1945 session of the General Assembly. "Indiana has made more rapid progress in the administration of that law than any other state. A major share of credit for this is due to the chairman of the licensing council, Dr. Clauser. All of us have been very happy with the splendid way in which he has conducted the council meetings. During the two years that the law has been operating in our state there has been a minimum of irritation. However, we feel that now, after two years of operation, it might be well to have an evaluation of the methods and procedures that have been used in the administration of this law. We have asked the Hospital Association to appoint a committee to study the procedures that have been used, and we would like to suggest to you, for your consideration, the appointment of a similar committee to work with, or separately from, the hospital association committee, to evaluate the methods of procedure we have used, in order that we may find out what we have been doing wrong, what we have done right, and what changes we might make to establish a more effective program."

DR. CLARK: Each councilor is asked to evaluate the hospitals in his respective district. The A.M.A. sends out a group of rules which the evaluator is supposed to follow, but maybe Dr. Burney's group has other rules superimposed. If we are going to do this thing on a factual, basic level, I think it would be well if a committee were appointed from this body to establish rules, et cetera, in conjunction with, or superimposed upon, the A.M.A.'s rules. It will help Dr. Burney, it will help us, it will help the A.M.A., and everybody. I make that a motion. (Motion seconded by Dr. Mitchell, and carried.)

DR. CLAUSER: I think that this is a very, very valuable move. The licensure council has been in existence only two years. Indiana has been one of the first states to utilize hospital licensing procedures. As a member of the council, I will say that it is the prime objective of the council to do a good job; it is necessary that we do a good job. I believe that such a committee is going to be valuable not only to the agencies Dr. Clark has mentioned but also to the Council.

2. *Annual registration law.* DR. PAUL TINDALL, secretary, State Board of Medical Registration and Examination: As with all new laws, the 1947 Medical Registration Act has presented difficulties in regard to administration, which your State Board of Medical Registration and Examination has endeavored to iron out to the mutual advantage of the medical licensees and the Board. I think I can safely say there has been but little adverse comment. Previous to the effective date of this Act the Board sent Miss Kirk, our Executive Secretary, to other states where similar laws have been enacted to learn of their mistakes and problems. These visits proved invaluable to us in setting up our registration machinery.

We were finally able to secure from the Attorney General's office an interpretation of the law, whereby the medical licensee is not required to present evidence that he has paid his poll and property tax before registering, as is required by other boards in annual registration. This interpretation has saved

endless annoyance, misunderstanding and correspondence to all concerned. The Attorney General has further ruled that the individual is registered, not the license. Therefore, certain drugless licensees who hold two or three types of licenses are required to pay but one registration fee.

Since 1897 more than 15,000 doctors have been granted certificates for licensure. The percentage of this number who are deceased, retired, or living permanently in other states is not known, since the Board, previous to July, 1947, had no funds to employ the necessary personnel to attempt to boil down this list to those now actually in practice. We are now starting to survey every folder in our files, which date back to 1897, as stated. We hope to have, within the next year or two, a fairly accurate list of Indiana licensees who are registered or eligible for registration, with the current address of each.

Up to about a week ago we had registered 3,782 physicians who reside in Indiana, in addition to 70 osteopaths, 39 medical-osteopaths, and 446 drugless practitioners. We have also registered 237 non-resident practitioners of all kinds. To date, more than 50 licensees have had to pay the penalty fee because they failed to register before the last day of August.

You may be interested in the fact that the Board anticipates the survey and evaluation of the six osteopathic medical schools for approval or disapproval as soon as the questionnaires are returned by these schools, all of which have signified their desire to be surveyed. This is necessary to comply with the provisions of the osteopathic unlimited practice Act, passed in 1945. The Attorney General's office has interpreted this Act to mean, in substance, that hereinafter, all osteopaths will be given the same examination as is given to graduates of medical schools, and all those passing such examination will be granted certificates for a license to practice medicine in unlimited form.

Dr. Mitchell made a motion that the Association go on record as approving that the State Board of Medical Registration and Examination adopt the same principles for approval of osteopathic schools as it does for colleges of medicine and comparable to the A.M.A. (Motion seconded by Dr. Garber, and carried.)

3. *Legislative matters.* Dr. Norman M. Beatty, co-chairman of the Committee on Public Policy and Legislation, brought to the attention of the Council several matters of interest to the association.

4. *Auditing Committee report,* as published in the October JOURNAL, was accepted.

5. *Executive Committee matters.* Dr. McCaskey, chairman, presented the following matters from the Executive Committee to the Council for action:

a. *Instructional courses.* Executive Committee recommends that a budget be set up for the Instructional Course Committee and in the future its expenses be handled in the same manner as those of other committees. (This recommendation was adopted by the Council on the motion of Drs. Mitchell and Howard.)

b. *1948 Annual Session.* Executive Committee recommends that the 1948 annual session be held the week of October 25. (This recommendation was adopted by the Council on the motion of Drs. Clark and Mitchell.)

c. JOURNAL *subscription rate.* Executive Committee recommends that the subscription price for members of the association be increased from $2.00 to $3.00, due to the high cost of production of THE JOURNAL. (On motion of Dr. Mitchell, duly seconded, this recommendation was approved.)

6. *Mutual Medical Insurance, Inc.* Dr. Kennedy reported a "profit surplus of $200,000" with gross assets of $400,000. The plan now covers a total of about 135,000 persons for both surgical and medical care. The general practitioner is receiving almost 50 per cent of the fees paid.

7. *Complaint on editorial note.* Dr. Clark called attention to an editorial note carried in the October JOURNAL regarding the Indianapolis City Hospital budget, and made the motion "that THE JOURNAL make an explanation of such an editorial, since it was written without proper delineation of facts. I move you that we apologize editorially in THE JOURNAL." (Motion seconded by Dr. Mitchell.)

Dr. Forster said the information presented in the editorial was obtained from a news clipping and that the facts as presented by Dr. Clark were not known. He assured the Council that the editor would be glad to make an explanation.

Following further discussion by Drs. Hauss and Clark, the motion was passed.

8. *Election of editor and associate editor of* THE JOURNAL *for 1948.* Upon motion of Drs. Clark and Kennedy, Dr. E. M. Shanklin, Hammond, was re-elected editor, and Dr. N. K. Forster, Hammond, was re-elected associate editor of THE JOURNAL for 1948.

9. *Election of Editorial Board members.* On ballot vote, Dr. Kenneth G. Kohlstaedt, Indianapolis, and Dr. J. T. Oliphant, Farmersburg, were elected members of the Editorial Board, to serve for three years and to succeed Dr. Bert Ellis, Indianapolis, and Dr. Charles N. Combs, Terre Haute.

10. *Prorating of association dues.* On motion of Drs. Mitchell and Clark, which was carried, beginning January 1, 1948, association dues are to be prorated as follows:

Physicians applying for membership during the

first nine months of the year will pay $15.00; dues for those who join after October 1 will be $5.00.

This action was taken in order that a number of the younger physicians may become members of the association in October or November without payment of a full year's dues for a few months' membership.

11. *Resolution regarding Study of Cost of Training School Operation.* Dr. Clark read the following resolution which was referred to the House of Delegates:

Be It Resolved, That the Indiana State Medical Association join with the Indiana State Nursing Association and the Indiana Hospital Association in the study of cost of Training School operation as set forth in the resolution* adopted by the Indiana Hospital Association.

*(See House of Delegates minutes, page 1286).

12. *Hoosier Farmer advertising.* As a matter of information, the secretary reported that in the future the *Hoosier Farmer* will carry "only the most reputable advertisements."

Date for Midwinter Council Meeting

The Council set Sunday, January 18, 1948, as the date for the midwinter meeting. The members of the Council agreed that it is inadvisable to hold the Secretaries' Conference and the midwinter Council meeting on the same day.

There being no further business, the Council adjourned at 3:45 P.M., to meet again on Thursday, October 30, following adjournment of the House of Delegates.

RAY E. SMITH,
Executive Secretary.

THE COUNCIL
(French Lick Session, 1947)

Second Meeting

The second meeting of the Council convened immediately following the adjournment of the House of Delegates, Thursday afternoon, October 30, 1947, with Dr. Alfred Ellison, the chairman, presiding.

Roll call showed the following members present:

Councilors:

First District ——— I. C. Barclay, Evansville
Second District ——— Not represented
Third District ——— A. P. Hauss, New Albany
Fourth District ——— Not represented
Fifth District ——— A. M. Mitchell, Terre Haute
Sixth District ——— W. U. Kennedy, New Castle
Seventh District ——— Cyrus J. Clark, Indianapolis
Eighth District ——— E. H. Clauser, Muncie
Ninth District ——— Not represented
Tenth District ——— W. H. Howard, Hammond
Eleventh District ——— C. S. Black, Warren
Twelfth District ——— Paul A. Garber, South Whitley
Thirteenth District ——— Alfred Ellison, South Bend

Officers:

Floyd T. Romberger, Lafayette, president
Cleon A. Nafe, Indianapolis, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
Ray E. Smith, executive secretary

Employment of Field Secretary

The chairman read the following resolution which was adopted by the House of Delegates:

RESOLVED, That the permanent Committee on Medical Education and Hospitals be instructed to study the matter of employment of a field secretary or secretaries and report its findings to the Council; and

BE IT FURTHER RESOLVED, That this House of Delegates empower the Council to take such action as it may deem proper and wise in regard to the report of the Committee on Medical Education and Hospitals.

Any recommendations which the Committee on Medical Education and Hospitals may make will be reviewed by the Council and action taken at a subsequent meeting of the Council.

Vote of Appreciation

On motion of Drs. Clark and Kennedy the Council instructed the secretary to write to Dr. Hauss and Dr. Boyd, co-chairmen of the Convention Arrangements Committee, and the organizations which worked on the annual session arrangements, expressing the appreciation and thanks of the Council for their services in making the 1947 convention one of the best ever held.

Secretaries' Conference

Dr. Mitchell announced that the Secretaries' Conference will be held on February 15, 1948.

Appreciation of President

On motion of Dr. Clark, duly seconded and passed, the Council instructed the secretary to write a letter to Dr. Floyd T. Romberger, president, thanking him for his unstinting service, his tireless efforts, and his efficient management of association affairs during the past year.

Refurbishing of Headquarters Offices

It was taken by consent, on motion of Dr. Clark, that the Council appropriate a reasonable amount of money for the refurbishing of the headquarters offices.

No further business appearing, the Council adjourned.

RAY E. SMITH,
Executive Secretary.

INDIANA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES
(French Lick Session, 1947)

First Meeting

The first meeting of the House of Delegates of the 1947 session convened in the Main Convention Hall, French Lick Springs Hotel, at 4:10 p.m., Tuesday, October 28, 1947, with the president, Dr. Floyd T. Romberger, of LaFayette, presiding.

A motion was made, duly seconded, and carried, to dispense with roll call, and to have the attendance slips which were distributed constitute the roll call of the House. These slips showed the following members present:

County	*Delegates*
Allen	M. B. Catlett, Fort Wayne
	Arnold H. Duemling, Fort Wayne
	Maurice E. Glock, Fort Wayne
	H. Vaughn Scott, Fort Wayne
Bartholomew	J. E. Dudding, Hope
Boone	Charles O. Weddle, Lebanon
Carroll	C. L. Wise, Camden
Cass	E. B. Jewell, Logansport
Clark	E. P. Buckley, Jeffersonville
Clay	J. Frank Maurer, Brazil

County	*Delegates*
Clinton	C. D. Holmes, Frankfort
Daviess-Martin	A. G. Blazey, Washington
Dearborn-Ohio	J. K. Jackson, Aurora
Decatur	Boyd L. Mahuron, Greensburg
Delaware-Blackford	O. A. Hall, Muncie
	Gerald S. Young, Muncie
Dubois	G. A. Held, Jasper
Elkhart	A. C. Yoder, Goshen
Fayette-Franklin	H. N. Smith, Brookville
Floyd	William H. Garner, New Albany
Fountain-Warren	Lee Maris, Attica
	Lowell R. Stephens, Covington
Gibson	Virgil McCarty, Princeton
Hamilton	John S. Hash, Noblesville
Hancock	Joseph L. Allen, Greenfield
Harrison	William E. Amy, Corydon
Hendricks	O. T. Scamahorn, Pittsboro
Henry	Walter M. Stout, New Castle
Howard	Elton R. Clarke, Kokomo
Huntington	G. M. Nie, Huntington
Jasper-Newton	Richard Schantz, Remington
Jay	George V. Cring, Portland
Jennings	D. W. Matthews, North Vernon
Johnson	W. L. Portteus, Franklin
Knox	Virgil C. McMahan, Vincennes
Kosciusko	Dan L. Urschel, Mentone
Lake	J. Robert Doty, Gary
	H. W. Eggers, Hammond
	C. M. Jones, Whiting
	G. L. Verplank, Gary
	Milton B. Gevirtz, Hammond
Lawrence	Claude O. Dollens, Oolitic
Madison	G. B. Wilder, Anderson
	C. V. Rozelle, Anderson
Marion	James F. Balch, Indianapolis
	R. M. Dearmin, Indianapolis
	Murray DeArmond, Indianapolis
	Bert E. Ellis, Indianapolis
	Roy A. Geider, Indianapolis
	E. V. Hahn, Indianapolis
	Foster J. Hudson, Indianapolis
	Harry E. Kitterman, Indianapolis
	Marlow W. Manion, Indianapolis
	Dudley A. Pfaff, Indianapolis
	Frank B. Ramsey, Indianapolis
	Dan E. Talbott, Indianapolis
	Chas. F. Thompson, Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	H. E. Rendel, Mexico
Montgomery	James M. Kirtley, Crawfordsville
Morgan	R. W. VanBokkelen, Mooresville
Noble	C. E. Munk, Kendallville
Orange	Clarence E. Boyd, West Baden Springs
Owen-Monroe	William A. Karsell, Bloomington
	M. S. Brown, Spencer
Parke-Vermillion	Joseph R. Bloomer, Rockville
Porter	John Ray Frank, Valparaiso
Pulaski	Charles E. Linton, Medaryville
Putnam	F. R. Dettloff, Greencastle
	James B. Johnson, Greencastle, alternate
Randolph	J. S. Robison, Winchester
Ripley	L. H. Hopkins, Versailles
Rush	Melvin H. Denny, Rushville
St. Joseph	Erwin Blackburn, South Bend
	F. R. Nicholas Carter, South Bend
	Josephine F. Murphy, South Bend
Scott	Carl R. Bogardus, Austin
Shelby	Roger F. Whitcomb, Shelbyville
Tippecanoe	Gordon A. Thomas, Lafayette
	Raymond R. Calvert, Lafayette
Tipton	S. M. Cotton, Goldsmith
Vanderburgh	Paul D. Crimm, Evansville
	C. C. Herzer, Evansville
	Minor Miller, Evansville
Vigo	A. W. Cavins, Terre Haute
	M. C. Topping, Terre Haute
Wabash	G. W. Seward, North Manchester
Warrick	W. C. Stover, Boonville
Wayne-Union	Harry Plummer Ross, Richmond
	W. A. Thompson, Liberty
Wells	Truman E. Caylor, Bluffton
Whitley	B. F. Pence, Columbia City

Councilors

1st District—I. C. Barclay, Evansville
2nd District—J. H. Crowder, Sullivan
3rd District—A. P. Hauss, New Albany
6th District—W. U. Kennedy, New Castle
7th District—C. J. Clark, Indianapolis
8th District—E. H. Clauser, Muncie
10th District—W. H. Howard, Hammond
11th District—C. S. Black, Warren
12th District—Paul A. Garber, South Whitley
13th District—Alfred Ellison, South Bend

Past Presidents

Charles N. Combs, Terre Haute
G. R. Daniels, Marion
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
R. L. Sensenich, South Bend
Herman Baker, Evansville
K. R. Ruddell, Indianapolis
A. M. Mitchell, Terre Haute
M. A. Austin, Anderson
C. H. McCaskey, Indianapolis
J. T. Oliphant, Farmersburg
N. K. Forster, Hammond
J. E. Ferrell, Fortville

Officers

Floyd T. Romberger, Lafayette, President
Cleon A. Nafe, Indianapolis, President-elect
A. F. Weyerbacher, Indianapolis, Treasurer
Ray E. Smith, Executive Secretary

Delegates to A.M.A.

Don F. Cameron, Fort Wayne
H. G. Hamer, Indianapolis

Dr. William E. Amy, chairman of the Committee on Credentials, announced that a constitutional quorum of delegates was present.

THE PRESIDENT: According to Chapter IV, Section 3, of the By-Laws, twenty delegates constitute a quorum. The House of Delegates, therefore, is declared open and ready for the transaction of business.

The By-Laws may be amended at any annual session by a *majority vote of all delegates present at that session,* after the amendment has laid on the table for one day. (Chapter XIV, Section 1, of By-Laws.)

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of all delegates present* at any annual session provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association. (Article XIV, Constitution).

We now pay tribute to the memory of those who were members of this House of Delegates, or who

served the state association in an official capacity —all laborers in the vineyard of this great Indiana State Medical Association—and who have died since the 1946 annual session. I shall read their names:

F. E. BASS, Shelbyville. Secretary, Shelby County Medical Society, 1920 through 1932.

LOUIS D. BELDEN, Indianapolis. Member of Liaison Committee with Indiana Crippled Children's Bureau, 1938 and 1939.

C. E. CARNEY, Delphi. Delegate from Carroll county, 1940 and 1941.

C. E. COTTINGHAM, Indianapolis. Member of Committee on Arrangements, 1910-1911; chairman of Committee on Scientific Work 1921.

F. C. DILLEY, Brazil. Secretary Clay County Medical Society 1914, 1922 through 1925; delegate from Clay county 1936.

G. M. FREEMAN, Shoals. Secretary Martin County Medical Society 1920 and 1921.

HARRY E. GABE, Indianapolis. Member of Committee on Arrangements 1918.

EARL R. GIBBS, Wilkinson. Secretary Hancock County Medical Society 1908 through 1912.

JOHN HABERMEL, New Albany. Delegate from Floyd county 1943.

KING L. HULL, Bloomfield. Secretary Greene County Medical Society 1931; member of Medical Relief Committee 1945 and 1946; delegate from Greene county 1937, 1938, 1942, 1943, 1944 and 1946.

JOHN M. JACKSON, Aurora. Secretary Dearborn-Ohio County Medical Society 1921 and 1923.

D. O. KEARBY, Indianapolis. Vice-chairman 1924 and chairman 1925 of Eye, Ear, Nose and Throat Section; chairman of Committee on Lye Burns in Children 1934 through 1936.

B. V. LALLY, Tell City. Delegate from Perry county 1939 through 1941.

SIMEON LAMBRIGHT, Covington. Delegate from Fountain-Warren County Medical Society 1934 through 1939.

W. T. LAWSON, Danville. Secretary Hendricks County Medical Society 1908 through 1946; first vice-president 1923.

OSCAR E. LINDENMUTH, Indianapolis. Member of Committee on Scientific Demonstrations 1914 and 1915.

FRANCIS V. MARTIN, Michigan City. Secretary LaPorte County Medical Society 1912.

W. M. McGAUGHEY, Greencastle. Member of Committee on State Medicine 1912 and 1913.

SHERMAN L. McKINNEY, Huntingburg. Secretary Dubois County Medical Society 1915; delegate from Dubois county 1945 and 1946.

GEORGE B. MORRIS, Bluffton. Secretary Wells County Medical Society 1920, 1935, 1936 and 1942.

HARRY M. PELL, Brazil. Secretary Clay County Medical Society 1919; member of Committee on Diphtheria Prevention 1933; delegate from Clay county 1934.

PHILIP H. SCHOEN, New Albany. Secretary Floyd County Medical Society 1915, 1917 through 1940; member of Committee on Secretaries' Conference 1932; member of Committee on Credentials 1933 through 1935; delegate from Floyd county 1934, 1935, 1937 through 1939.

L. O. SHOLTY, Lafayette and Wabash. Secretary Wabash County Medical Society 1917 through 1920.

O. R. SPIGLER, Terre Haute. Member of Committee on Arrangements 1908-1909; member of Committee on Public Policy and Legislation 1909-1910; third vice-president 1921; member of Committee on Study of Health Insurance 1934 through 1936; member of Committee on Control of Cancer 1940; member of Committee on Postwar Medical Service 1945 and 1946; delegate from Vigo county 1934 through 1942.

H. C. WADSWORTH, Washington. Secretary Martin County Medical Society 1914 through 1918 and 1921 through 1929; member of Committee on Secretaries' Conference 1930 and 1931; member of Committee on Study of High School Athletics 1933 through 1944; member of Committee on Pneumonia 1939 through 1942; member of Committee on Industrial Health 1944; member of Committee on Physical Fitness 1945; Councilor of Second District 1931 through 1945.

JOSEPH H. WILLIS, Evansville. Member of Committee on Tuberculosis 1909-1910; councilor of First District 1921 through 1924.

J. P. WILSON, Scottsburg. Secretary Scott County Medical 1916 until the time of his death, September 23, 1947.

Will the House please rise in silent tribute?

(On motion of Drs. George Daniels and O. A. Hall, the minutes of the previous meetings, as published in THE JOURNAL, were approved.)

THE PRESIDENT: I want to express my appreciation for the remarkable attendance here this afternoon. I have sat in this House of Delegates when only half of the members were here. Gentlemen, I salute you!

(At this time Dr. R. L. Rutledge, Alliance, Ohio, president of the Ohio State Medical Association, Dr. John D. VanNuys, Indianapolis, dean of the Indiana University School of Medicine, and Dr. R. L. Sensenich, South Bend, president-elect of the American Medical Association, were introduced. Dr. Rutledge extended an invitation to all members of the Indiana State Medical Association to attend the annual meeting of the Ohio State Medical Association, to be held at Cincinnati March 30 to April 1, 1948.)

DR. JOHN D. VANNUYS, Indianapolis: Dr. Romberger, members of the House of Delegates: I consider it a very great honor indeed to be invited to appear before this group. I wish particularly to thank President Romberger and the members of the Council of the Indiana State Medical Association for extending the invitation. I have but a few moments to spend with you, but in that time wish to cover two or three points in relation to the problem of medical education in general and to tell you of the things that we are attempting to do in our own school of medicine here in Indiana.

There are many problems before schools of medicine at this time. One of the main questions is whether or not we are graduating enough physicians. If we listen to the words of some authorities we would say that there is a shortage of 15,000 to 20,000 doctors in the United States. Dr. Parran of the U. S. Public Health Service is reported to have made the statement that 15,000 physicians are needed in public health. Many more physicians are now being used in industry, in federal, state, county and city institutions, and in the armed forces than

was true before the war. This might argue for an increase in the number of physicians graduated each year. On the other hand, most of us here remember the recent economic depression and we recall that at that time physicians were indeed plentiful. There are 69 accredited schools of medicine in the United States and Canada and these schools graduate between 5,500 and 6,000 doctors a year. Our school of medicine in Indiana has the fifth largest enrollment of students of this entire group. Although the enrollment is large we stand approximately seventeenth in area and evaluation of physical plant, and approximately thirty-seventh in the number of full time faculty. There is a very serious question in my mind as to whether, with our present facilities, we could expand enrollment without seriously affecting the quality of medical training. An increase in enrollment could only be accomplished through considerable expansion of our physical plant and by spending a great deal more money. Indiana, being near the top of the list in enrollment, is, perhaps, doing its share in graduating doctors. If all of the medical schools of the United States and Canada admitted and graduated as many students as does Indiana University each year, there would be 1,900 additional physicians available annually for public service.

As a second question before medical schools the matter of admissions has caused considerable comment. Many believe that our admission requirements are too high. I do not believe this to be true. Scholastically, our school requires a C-plus average. This means that any boy or girl in the State of Indiana who has 94 hours of collegiate work, half of them of C grade, and half of them of B grade, may be eligible for admission provided they are of good character and have good health. I am almost ashamed to tell you that no graduate school in our state has entrance requirements as low as does the school of medicine. In graduate schools usually a B average or better is a standard admission requirement. Up to and including this year every boy and girl in the State of Indiana who has met the requirements listed above was admitted to the School of Medicine. The Faculty Committee on Admissions accepted 141 students to the school for the class beginning last September. It is difficult to predict what the problem will be next year. Perhaps there will be a few more eligible candidates for admission.

One or two points regarding our present activities. In your previous meetings you have asked for an increased support of the medical school in the matter of budget. We deeply appreciate your interest in this as it brought to the attention of the Board of Trustees of Indiana University the urgent need of more liberal support for the school. We have had a very generous increase in the budget both last year and for the present fiscal year. In fact, the President of the University recommended a larger appropriation for the school than was originally contemplated by the school administration. We now have a budget that exceeds $800,000 which is one of the largest budgets for medical schools, particularly state medical schools, in the United States. The friendly attitude displayed by the President and Board of Trustees of the University gives us every reason to feel that we will be kindly treated in the future.

One of the principal problems before us and one of our chief handicaps is that we are a split school. As you know, the first year of instruction is given on the Bloomington campus and we have little opportunity to develop anatomy and physiology on the main campus of the school of medicine at Indianapolis. I need not go into detail with you as to the difficulties that this arrangement presents in our planned revision of the curriculum and in our attempt to carry on adequate postgraduate courses. I feel that it is definitely necessary to have the first year of medicine brought to Indianapolis as quickly as possible. We are making every effort to accomplish this end. The President of the University has appointed a committee of the faculty to make a complete study and report to him on the feasibility of moving the school. The committee is compiling a report on the cost, when the change can be made, and on the manner in which the first year may be transferred. I believe that we would have a better balanced curriculum if we were able to distribute anatomy and physiology through three or four years of the medical course and to make the applied aspects of these important basic sciences available to students in the upper classes, to our interns, the resident physicians studying in specialties, and to the many physicians who return to the campus for refresher courses. The work of the first year, if brought to Indianapolis, would not all be concentrated in two departments. It would seem wise and in line with plans of other schools to introduce some clinical instruction into the first year's work.

In expansion of the Medical Center campus the state has appropriated two million dollars for the construction of a new Board of Health building. The very fine building now occupied by the Board of Health will be given to the School of Medicine. In addition to this, the state in the near future plans to erect a three million dollar mental screening hospital and the United States Veterans' Administration plans an eight million dollar structure adjacent to the University Hospitals group. It should be pointed out that all of these state and federal facilities are being brought to the Medical Center campus because of the presence of our school of medicine in this location. The importance of additional facilities for the school to keep pace with the demands placed upon it must be emphasized to the next budget committee.

I deeply appreciate the friendly co-operation of the President, the members of the Council, and the membership of this entire organization. I know that the life of our school depends upon the support of the Indiana State Medical Association,

of which I am proud to be a member myself. I know that working together we can accomplish a great deal in this state. We appreciate very much the scholarships made available by you to the students in the School of Medicine interested in private practice in rural areas. We further wish to thank you for the scholarships for nurses, in which our Center participated. These are acts which will help us to become a stronger school. This is important, as we feel that with a strong school of medicine in this state we can go on to greater things and encourage the practice of medicine under a free system.

I wish to impress upon you that we are attempting to carry out the mandate of the delegates of previous years. You recommended a larger budget for the school. We asked for and received a generous increase. You asked that the business management of the school be placed in the hands of the medical administration and we have reasonable control of our business affairs. You have asked most urgently that the first year be brought to Indianapolis and I pointed out to you that a committee of the faculty is now busily engaged in working on this problem. In this regard I wish to warn you against any resolution or any intent to go directly to the legislature to achieve this end. I am sure no one in this room wishes the first year at Indianapolis more than do I; however, we must not establish a dangerous precedent. Moving our school is a matter of policy, to be determined by the Board of Trustees of the University, and not a matter which should properly come before the General Assembly. True, the legislature might look favorably upon the move and make it possible for this to be accomplished, however, it would feel free at later sessions to enter into the internal affairs of the school at will. We must stand together in this matter. Unless you wish to invite the legislature into the front door of private practice, do not invite it into policy making responsibilities for the school.

I deeply appreciate the opportunity of coming before you. We have great hopes for the future and we trust that you will give support to the Medical Center and the School of Medicine. We also need a little time in which to produce satisfactory results. Thank you. (Applause.)

THE PRESIDENT: According to Article V of the Constitution, the A.M.A. delegates have the right to sit in the House of Delegates, with the privilege of the floor, but with no power to vote. This has been interpreted to include alternates. They are:

Delegates	*Alternates*
H. G. Hamer, Indianapolis	K. R. Ruddell, Indianapolis
A. S. Giordano, South Bend	N. K. Forster, Hammond
D. F. Cameron, Fort Wayne	N. M. Beatty, Indianapolis
F. S. Crockett, Lafayette	A. M. Mitchell, Terre Haute

Gentlemen, we invite your very close attention and we invite your friendly and wholesome counsel.

All members of the association and all regularly registered guests of this association are invited to sit in on this meeting to hear the deliberations of the House.

In accordance with Chapter IX, Section 1, of the By-Laws, reference committees have been appointed by the president to serve during this session only. These committees should not be confused with the all-year round standing committees. All reports, resolutions, and measures presented to the House of Delegates at this session, except such matters as properly come before the Council, will be referred to these reference committees, and the recommendations of these committees shall be submitted at the last meeting of the House of Delegates, Thursday, October 30, at 11:30 a. m., for acceptance in the original or modified form, or for rejection. Each committee consists of five members, the first member named to act as chairman.

I shall now read these reference committees. Will you please stand so that each may know the others?

1947 REFERENCE COMMITTEES

1. **Sections and Section Work:**
 Chairman, C. S. Black, Warren (Huntington)
 Foster J. Hudson, Indianapolis (Marion)
 R. R. Calvert, LaFayette (Tippecanoe)
 Gerald S. Young, Muncie (Delaware-Blackford)
 Charles E. Gillespie, Seymour (Jackson)

2. **Rules and Order of Business:**
 Chairman, M. B. Catlett, Fort Wayne (Allen)
 E. B. Jewell, Logansport (Cass)
 S. M. Cotton, Goldsmith (Tipton)
 N. A. James, Tell City (Perry)
 John C. Glackman, Jr., Rockport (Spencer)

3. **Medical Education and Hospitals:**
 Chairman, Herman M. Baker, Evansville (Vanderburgh)
 Roy A. Geider, Indianapolis (Marion)
 F. R. N. Carter, South Bend (St. Joseph)
 Robert M. Dearmin, Indianapolis (Marion)
 C. V. Rozelle, Anderson (Madison)

4. **Public Policy and Legislation:**
 Chairman, E. Vernon Hahn, Indianapolis (Marion)
 Will A. Thompson, Liberty (Wayne-Union)
 J. R. Doty, Gary (Lake)
 J. Frank Maurer, Brazil (Clay)
 C. D. Holmes, Frankfort (Clinton)

5. **Publicity:**
 Chairman, Bert E. Ellis, Indianapolis (Marion)
 Lee Maris, Attica (Fountain-Warren)
 Irvin E. Huckleberry, Salem (Washington)
 Harry P. Ross, Richmond (Wayne-Union)
 E. E. Padgett, Indianapolis (Marion)

6. **Hygiene and Public Health:**
 Chairman, William H. Garner, New Albany (Floyd)
 Truman E. Caylor, Bluffton (Wells)
 M. C. Topping, Terre Haute (Vigo)
 Paul D. Crimm, Evansville (Vanderburgh)
 J. K. Jackson, Aurora (Dearborn-Ohio)

7. **Amendments to Constitution and By-Laws:**
 Chairman, Gordon A. Thomas, Lafayette (Tippecanoe)
 B. F. Pence, Columbia City (Whitley)
 G. L. Verplank, Gary (Lake)
 A. W. Cavins, Terre Haute (Vigo)
 Dan E. Talbott, Indianapolis (Marion)

8. Reports of Officers:
Chairman, A. C. Yoder, Goshen (Elkhart)
J. E. Ferrell, Fortville (Hancock)
Claude Dollens, Oolitic (Lawrence)
C. F. Briggs, Sullivan (Sullivan)
Joseph E. Dudding, Hope (Bartholomew-Brown)

9. Committee on Credentials:
Chairman, John S. Hash, Noblesville (Hamilton)
William Karsell, Bloomington (Owen-Monroe)
Joseph R. Bloomer, Rockville (Parke-Vermillion)
Richard Schantz, Remington (Jasper-Newton)
A. A. Wade, Howe (LaGrange)

10. Committee on Miscellaneous Business:
Chairman, Jacob T. Oliphant, Farmersburg (Sullivan)
Charles O. Weddle, Lebanon (Boone)
E. P. Buckley, Jeffersonville (Clark)
Albert M. DeArmond, Indianapolis (Marion)
J. M. Kirtley, Crawfordsville (Montgomery)

These reference committees should organize immediately after the adjournment of the House today.

Reports of Officers

The officers' reports, except the President's address to be delivered Wednesday morning, and the address of the President-elect, are printed in the October JOURNAL and in the Handbook, but each officer will receive five minutes in which to make any additions to or explanation of the reports already published. The President's address will be referred to the Reference Committee on Reports of Officers, and the Reference Committee on Amendments to the Constitution and By-Laws.

At this time it is my very great privilege to introduce to you Dr. Cleon A. Nafe, our President-elect.

Address of the President-elect

DR. CLEON A. NAFE: Mr. President, Members of the House of Delegates:

Again, I wish to express to this House of Delegates my appreciation of the high honor that you bestowed on me at your last meeting by electing me President of the Indiana State Medical Association for the year 1948. I doubt that I can make any contribution to the society that will justify that honor, but I assure you that I will earnestly endeavor to fulfill the duties of that office to the best of my ability. When I reflect upon the many problems that are confronting organized medicine, I am deeply cognizant of the fact that neither I nor any other officer alone can contribute much in behalf of medicine. However, our society is a respectable segment of organized medicine, and by a united effort we can contribute much that is in the interest of better medical care and we may influence materially the future pattern of the private practice of medicine.

I believe that most physicians are fully aware of the many problems that the medical profession faces. Yet, in order that we may all recognize the increasing complexity of our problems, I would like to review a few of these trends. In recent years there have appeared an increasing number of articles in the lay press criticizing the present medical care program. These complaints have been mainly about the high cost of medical care, the lack of adequate medical care, the poor distribution of medical care, and statements that a large segment of our boys of draft age were rejected because of disabilities related to the lack of proper medical care. Recently a prominent surgeon was quoted in the lay press that 40 per cent of surgical procedures now carried out are unnecessary. Without entering into any discussion of the merits of these statements it is evident that such publicity undoubtedly tends to make the public and our legislators have some doubt about the efficiency of our present system of the practice of medicine. We as physicians must utilize every means at our command to correct this misinformation and must correct any errors in the present medical care facilities if they do exist.

Various units of government have gradually become interested in medical care problems, so that now almost every unit of government, city, county, state, and federal, are participating in medical care projects. Recently there has been introduced into Congress the Wagner-Murray-Dingell bill that would make the federal government the supervisor of almost all of the private practice of medicine. That measure is supported by the President of the United States, Surgeon General Parran, President Green of the A. F. of L., President Murray of the C.I.O., and many other prominent so-called progressive political leaders. Only the fact that our present Congress is more conservative has given the medical profession a breathing spell in its fight against this revolutionary piece of legislation. With the powerful support that this type of legislation has we may be sure that it will be proposed again, and it will require the full support of all of its opponents to defeat it.

Many groups such as the American Cancer Society, the Foundation for Infantile Paralysis, the Sister Kenny Foundation, the Society for Crippled Children, the American Heart Association, and others, have become more prominent in their activities that are closely related to the practice of medicine.

The greatly increased sale of surgical and hospital care plans by both commercial and nonprofit organizations sponsored by hospitals and physicians have increased the interest of another group as the third party in the care of the sick.

The great increase in the facilities of the Veterans Administration for the medical care of all sick veterans, and the increase in the sphere of activities of the Public Health service of the United States, and of various State Boards of Health adds another large group of people securing their livelihood from the care of the people's health.

All of this indicates a great interest on the part of the people in their health problems, and it is

a challenge to the medical profession to direct properly the present trends so that they may be useful and not detrimental to the ultimate goal, which should be better health for all the people. Neither the physicians nor the public, when they are properly advised, want federalized medicine. Yet the public wants the best in medical care and they want to be able to pay for it. It is our duty to aid them in that objective and advise them wisely. If government aid is necessary it should be used properly. As a small united minority we should be able to mold the present trends in such a way that the private practice of medicine is preserved, if we strive diligently, and if our deportment merits public acclaim.

The question always arises as to what we as physicians may do to direct these many changes.

Much is being said in various medical gatherings about the public relations of the medical profession. Several state societies, notably California, Ohio, Michigan, and others, have employed public relations counsel, and are conducting extensive public relations programs at considerable cost to those societies. A few of our medical leaders think that our state society should embark upon a similar program. I have an open mind concerning this. The American Medical Association employed the Raymond Rich Company as counsel two years ago. This year at Atlantic City that relationship was terminated, as you already know.

Several months ago I attended a meeting of a group of public relations counsel of State Medical Associations and others interested in medical public relations, at Chicago. Some of those present were employed as public relations counsel by state societies, others were seeking employment, and others were there, like myself, to be informd. Several definitions of medical public relations were given, such as "enlightened conduct properly executed and then effectively translated and interpreted to the public through various mechanisms, including publicity." Some of those present advocated the use of newspapers and radio on a national scale to provide news and information to enlighten the public concerning what the medical profession is accomplishing. Others held that the public already was well informed and well impressed by the great achievements of the medical profession, and that the real public relations job has to be done on a local level by the county medical society and the individual practitioners of medicine in the proper care of their patients.

A cross section of the views at that meeting and other discussions would indicate that our job of public relations must be at three levels, the individual physician, the county medical society, and the state society. During the present year Doctor Romberger has continually stressed the need for better medical organization. With that objective I heartily agree. I would like to urge this coming year that the chief objective of our state and county organizations be a planned improvement of our public relations. I believe we have done fairly well in the past but that we can do much better now that there is some degree of stability, since most of our physicians are again settled in practice following the recent world-wide upheaval.

What can the individual physician do in this regard?

One public relations counsel has suggested that each physician confront himself with such questions as—Am I giving my patients careful consideration and the best medical care that I can furnish? Do I give them all the medical attention they need and no more? Am I considerate of their financial status? Are my fees reasonable? Have I done everything possible to create a feeling of satisfaction in my patient as a result of his professional relationship with me? In short, am I a conscientious physician? I believe the great majority of our physicians could answer the above questions in the affirmative. However, there are always a few physicians who do not conform to the accepted traditions of the medical profession and by their acts destroy a lot of the good will that has been created by others. Unfortunately too many physicians do not seem to realize that the misconduct of one physician is attributed to his organized group. For that reason the county medical society has a serious responsibility of disciplining those few wayward members, and I believe they should be more vigilant in that regard. Since more hospitals are being built in many communities, the physicians have an added responsibility of properly controlling the professional activities of the staff and must use wise judgment in the many decisions pertaining thereto. Recently there has been a nation-wide trend to limit staff memberships in various hospitals to those holding certification by national boards, or membership in special societies. I wish to call attention to the action of the House of Delegates of the A.M.A. in criticising this method, and insisting that staff membership be open to all members of the profession on a basis of their qualifications as determined by those physicians in their own community. It is imperative that staff membership be determined on a basis of qualifications and not on any selfish or other ulterior motive. The county society may be a potent force for good public relations by giving constructive advice concerning all health projects in its community, and by providing adequate medical care for all its people.

Whether the state association should embark upon a more aggressive information program than already is in operation must be decided by this House of Delegates and the Council. We have done well but we could do more. The state association must continue a spirit of friendly co-operation and constructive criticism of all state-wide agencies concerned with problems of health, such as Indiana University, the State Board of Health,

the Indiana Cancer Society, Foundation for Infantile Paralysis, et cetera.

I believe that all our physicians should earnestly support Mutual Medical Insurance, Inc., which our association has sponsored. It is our answer to compulsory insurance and we must take a definite interest in correcting any of its mistakes and seeing that it does the best job that is possible.

The trend toward over-specialization, brought about in a large measure by World War II, has created new problems throughout all of the United States. Medical schools and many medical societies have been especially concerned with the trend and are discussing methods of interesting more of our younger physicians in the general practice of medicine. The general practitioner has become too unimportant in the scheme of things, and his interests should be protected more forcibly by our society. He comprises the major portion of our organization, but he usually is too busy taking care of the sick people to be as active as the specialists in medical societies. It is in the interest of our society that we take special measures to assure him of his rights and privileges, and to stress his importance. Our society has given to him a special section. Recently the A.M.A. has announced that they will give annually a special gold medal award to honor a general practitioner who has served his community with distinction. This is for the purpose of further emphasizing the importance of the general practitioner. In order that we may properly do our part as a state society in this regard, I propose that each year the House of Delegates make a similar award, that the candidates be proposed in writing to the Council and from these three be selected by the Council, to be voted upon by the House of Delegates, and that the one receiving a majority vote by that body be given the award, to be called the General Practitioner Award of the Indiana State Medical Association.

In closing, let me urge that every effort be made during this year to improve our public relations. Let us fight to the bitter end all undesirable legislative proposals that are not in the interest of good medical care, but let us always be constructive and helpful in dealing with all agencies, either public or private, which are concerned with problems of health.

The complexities of the problems that confront organized medicine have multiplied many times since those of us in this room began the practice of medicine. They will probably become more complex, but I am sure that the medical profession will always retain its enviable position, if we all assume our proper responsibilities.

(Referred to Reference Committee on Reports of Officers.)

Report of Executive Secretary

Referred to Reference Committee on Reports of Officers.

Report of Treasurer

Referred to Reference Committee on Reports of Officers.

Report of Chairman of Council

Referred to Reference Committee on Reports of Officers.

REPORTS OF STANDING AND SPECIAL COMMITTEES

THE PRESIDENT: These reports are printed in the October JOURNAL and in the Handbook, but each chairman will receive five minutes in which to make any additions or explanation to his report, if he so desires.

Committee on Credentials

Referred to Reference Committee on Credentials.

Executive Committee

Published report referred to Reference Committee on Reports of Officers.

DR. C. H. McCASKEY, chairman: The committee has this supplemental report to make. The Executive Committee, by motion adopted October 27, 1947, recommends to the House of Delegates that it direct the Committee on Public Policy and Legislation to prepare and introduce in the 1949 General Assembly of Indiana a bill requiring all individuals using the prefix "Doctor" also to use an abbreviation suffix explaining the kind of doctor degree held by the individual. Such a law is now in effect in Missouri and other states.

Supplemental report referred to Reference Committee on Public Policy and Legislation.

Committee on Arrangements

DR. A. P. HAUSS, co-chairman: The committee has nothing else to report except that we are glad you are here and we are doing the best we can to take care of you.

Referred to Reference Committee on Miscellaneous Business.

Committee on Scientific Work

Referred to Reference Committee on Sections and Section Work.

Instructional Course Committee

Referred to Reference Committee on Medical Education and Hospitals.

Public Policy and Legislation

Referred to Reference Committee on Public Policy and Legislation.

Committee on Publicity

Referred to Reference Committee on Publicity.

Civic and Industrial Relations

Referred to Reference Committee on Public Policy and Legislation.

Medical Education and Hospitals

Referred to Reference Committee on Medical Education and Hospitals.

Public Relations

Referred to Reference Committee on Public Policy and Legislation.

Journal Publication Committee

Referred to Reference Committee on Reports of Officers.

Secretaries' Conference

Referred to Reference Committee on Miscellaneous Business.

Scientific Exhibit

Referred to Reference Committee on Sections and Section Work.

Necrology and History

Referred to Reference Committee on Miscellaneous Business.

Mental Health

Referred to Reference Committee on Hygiene and Public Health.

Maternal and Child Health

Referred to Reference Committee on Public Policy and Legislation.

Liaison Committee of the Division of Services for Crippled Children

Referred to Reference Committee on Public Policy and Legislation.

Auditing Committee

Referred to the Council.

Control of Cancer

Referred to Reference Committee on Hygiene and Public Health.

Venereal Disease

Dr. F. R. Nicholas Carter, chairman, presented the following report, which was referred to the Reference Committee on Hygiene and Public Health:

House of Delegates,
Indiana State Medical Association.
Gentlemen:

At a meeting of the Venereal Disease Committee held on September 24, 1947, the following matters were discussed and recommended for approval by the House of Delegates of the Indiana State Medical Association.

In order to secure better reporting of venereal disease cases, the State Board of Health presented a printed form for the committee's consideration. This form would be supplied to every physician in the State. It would contain the name and address of the infected individual, as well as certain other epidemiological data.

It was the opinion of the committee that the use of this form should be tried. It was suggested that an article explaining how to use the form be placed in the Indiana State Medical JOURNAL.

The committee again strongly recommends that drugs for the treatment of venereal disease be supplied by the State Board of Health for indigents only and that physicians making application for such drugs be required to state that they are for the treatment of indigents.

The committee recommended that all early cases of syphilis be treated in the local community in which they originate, rather than have them sent to a rapid treatment center as has been done in the past. The committee felt that this should be done in order to allow the physicians in the local community an opportunity to develop their own technique for handling these early cases. Since they are communicable diseases in a highly infectious stage it should be the duty of the Health Department to defray all necessary expense involved in their treatment.

The committee again recommended that the attention of the profession be called to the fact that the laboratory facilities of the State Board of Health are for indigent services only. A physician may send blood tests and other laboratory work to the State Board of Health laboratories. When he does so for other than indigent cases he retards the development of good laboratory services in his own community and thereby lowers the standard of all medical care.

The committee recommended that an effort be made to acquaint the profession with the difference between quantitative and qualitative blood tests. In the course of instruction in the medical school emphasis on the difference between the two types of blood tests should be made. Also, it seems desirable that an article be printed in the Indiana State Medical JOURNAL explaining in a very simple way the difference. For the present the committee feels that the profession should know:

1. That all routine diagnostic blood tests are qualitative tests.

2. That the use of the usual symbols 4 plus, 3 plus, 2 plus, 1 plus, and negative, are misleading. No patient or physician should use reports of this nature as indicative of the stage of the disease or as indicating the amount of improvement which has been accomplished by treatment.

3. That the measurement of the amount of liter per unit of blood, as is done in the quantitative test, can be used to determine the amount of improvement in the patient.

4. That many conditions, such as malaria, infectious mononucleosis, and other acute infectious diseases may cause false positives. In consideration of this fact a positive serology should always be checked by a second blood test before a positive diagnosis is made.

F. R. NICHOLAS CARTER, M.D., *Chairman*.
W. W. HEWINS, M.D.,
E. O. NAY, M.D.,
ERNEST RUPEL, M.D.,
T. R. HAYES, M.D.,
LOUIS SANDOZ, M.D.,
W. C. MCCORMICK, M.D.,
DON KELLY, M.D.

Industrial Health

Referred to Reference Committee on Hygiene and Public Health, Reference Committee on Sections and Section Work, and Reference Committee on Amendments to Constitution and By-Laws.

Committee on Indiana Inter-Professional Health Council

Referred to Reference Committee on Miscellaneous Business.

Anti-Tuberculosis Committee

Referred to Reference Committee on Hygiene and Public Health, Reference Committee on Sections and Section Work, and Reference Committee on Amendments to Constitution and By-Laws.

Conservation of Vision

Referred to Reference Committee on Hygiene and Public Health.

Medical Relief

No report submitted.

Rural Medical Care

The report published in the October JOURNAL and the following supplemental report presented by Dr. H. N. Smith, chairman, were referred to the Reference Committee on Public Policy and Legislation:

DR. H. N. SMITH: The Rural Medical Care Committee has had many difficulties. The doctors in the state do not seem to have placed enough importance on rural medical care. They don't seem to be interested in it, and we are having a lot of trouble in getting doctors to the meetings. We think this is a very important subject and therefore we think that other committees should keep this in mind and help to get this subject before the doctors of the state. Several things have been taken up by the committee; for instance, six scholarships have been allowed to take care of students who promise that they will spend a certain amount of time after graduation in districts where doctors are needed, but we think that much more could be done.

Lately, Mr. Mason, formerly of the State Board of Health, has been employed by the university to work in the extension department of Purdue University. He should be able to find out what is needed in the rural areas, with the aid of the local physicians and councilors, and be able to help us find out what should be done. The committee wishes to educate the rural people so they can help themselves. Purdue Extension Department has been very interested in this subject, but they believe that the thought of the medical profession is necessary, and they will be glad to work with the medical profession if we will work with them. It has been very difficult for just a few doctors to carry this load, so we hope that we may get some help from the other committees and the doctors.

Hard of Hearing

Referred to Reference Committee on Hygiene and Public Health.

Rehabilitation Services

Referred to Reference Committee on Miscellaneous Business.

Medical and Nursing School Scholarships

Referred to Reference Committee on Medical Education and Hospitals.

Centennial Celebration

Referred to Reference Committee on Publicity.

DR. CHARLES N. COMBS, chairman: We have a list of contributors to the Memorial Volume which is to be published in 1949, the same to be a history of Hoosier Medicine for the past one hundred years. Our committee meeting was held prior to the A.M.A. convention in Atlantic City, but since then I am proud to announce that an introductory chapter will be written by Dr. Roscoe L. Sensenich, president-elect of the A.M.A.

Veterans' Committee

Referred to Reference Committee on Miscellaneous Business.

State Fair

Referred to Reference Committee on Publicity.

Study of Undergraduate Medical Education

The following report was referred to the Reference Committee on Medical Education and Hospitals:

House of Delegates,
Indiana State Medical Association.
Gentlemen:

Your Committee on Undergraduate Medical Education met on call at the Columbia Club, Indianapolis, Indiana, at 10:00 a.m., Sunday, October 5, 1947. Members present were Dr. A. P. Hauss, chairman; Dr. Jesse E. Ferrell, Dr. Walter L. Portteus, and Dr. J. D. VanNuys. Absent committee member, Dr. O. O. Alexander. Others in attendance were Dr. Cleon A. Nafe, Dr. C. H. McCaskey, and Ray Smith, executive secretary, Indiana State Medical Association. The Committee, in formal session, considered the following in relation to undergraduate medical education in Indiana:

1. The apparent present shortage of physicians as emphasized by the lack of practitioners of medicine in many smaller towns and rural areas of the state.
2. The time required for a general practitioner of medicine to complete premedical, medical, and intern requirements in order to become available for actual service in the profession.
3. The question as to whether more physicians could not be graduated from the Indiana University School of Medicine with its present staff and physical facilities without lowering the quality of instruction.
4. How the Indiana State Medical Association can offer the greatest assistance in solving the present problems in the field of undergraduate medical education.

After hearing detailed reports from a number of committee members and considering the facts as presented, the membership was in agreement on the following points:

1. That the proper approach to the solution of the general problem of undergraduate medical education in Indiana should be the support of a close working relationship between the Indiana State Medical Association and the administration of the Indiana University School of Medicine.
2. That this committee and the Indiana State Medical Association stand firmly against any move which might lower the standards of medical education.
3. That more emphasis be placed on the humanitarian and less on the ultrascientific aspects of undergraduate medical education during the first year of the curriculum, with the primary idea of developing well qualified doctors to serve the public.
4. That there will be more medical graduates enter the general practice field if a greater differential is established in the requirements for general practitioners and certified specialists.
5. That Diplomates of any specialty board would be better qualified as a specialist, if a specified number of years in private general practice was a preliminary requirement for certification.
6. That this committee and the Indiana State Medical Association stand firmly behind the administration of the School of Medicine in its move to bring the first year of instruction to Indianapolis through the action of the school's faculty committee now preparing formal recommendations to the Board of Trustees of Indiana University regarding this important matter. That it support the school's program for revision of the curriculum and its requests for additional funds to strengthen its teaching staff, graduate education, research, and service programs.
7. That in view of the complexity of the problems confronting all schools of medicine and the medical profession in reference to graduate medical education, and with particular regard for the situation in our own state, it would appear wise to create a standing committee of the Indiana State Medical Association to conduct continued and prolonged studies, and that the findings and recommendations of this committee be reported at stated intervals to the Council of the State Medical Association and annually to the House of Delegates.

In support of the above findings and conclusions, your Committee on Undergraduate Medical Education proposes the following resolution:

WHEREAS: The Committee on Undergraduate Medical Education recognizes numerous problems in this field which are a serious concern to the membership of the Indiana State Medical Association in providing adequate medical care for the people of Indiana, and

WHEREAS: The solution of these problems, such as, whether there is actually a shortage of medical graduates, whether proper methods are being employed in the selection of medical students, whether the maximum number of physicians are being graduated by the Indiana University School of Medicine with its present plant and facilities, whether too long a time is required in the education of physicians, and whether too large a proportion of our medical undergraduates are being diverted to the specialty fields and too few to private general practice, are all of such complex nature that more time and thought must be expended before a complete program of action can be recommended to this House of Delegates, and

WHEREAS: The satisfactory operation of the Indiana University School of Medicine requires unqualified support of organized medicine in the State of Indiana; and

WHEREAS: It is deemed advisable that certain preliminary principles be established, approved or reaffirmed by this House of Delegates, as a guidance in the further study and solving of this complex problem;

Be It Resolved That the House of Delegates of the Indiana State Medical Association authorize the appointment by the President of a Permanent Study Committee on Undergraduate Medical Education to make a detailed and permanent study of the numerous problems in this field and to report as directed to the Council and House of Delegates,* and

Be It Further Resolved That the House of Delegates of the Indiana State Medical Association go on record in support of the administration of the Indiana University School of Medicine in its efforts to consolidate the school, to extend its faculty and improve its financial condition in order to improve the quality of medical instruction, and

Be It Further Resolved That the House of Delegates and Indiana State Medical Association reaffirm their position regarding the consolidation of the School of Medicine, and that this reaffirmation be directed to the Board of Trustees of Indiana University for its serious consideration, and

Be It Further Resolved That this committee report and resolution be respectfully submitted as a memorandum for the consideration of the Trustees of the American Medical Association, and the Trustees or Governing Boards of all the recognized specialties.

Respectfully Submitted,
THE COMMITTEE ON UNDERGRADUATE MEDICAL EDUCATION,
Authorized and appointed by the Council, Indiana State Medical Association.
AUGUSTUS P. HAUSS, M.D., *Chairman*
J. E. FERRELL, M.D.,
WALTER L. PORTTEUS, M.D.,
J. D. VANNUYS, M.D.,
O. O. ALEXANDER, M.D.

Mr. President, I move that the House of Delegates approve this committee report and adopt this resolution as submitted.

Communications

THE PRESIDENT: Communications that have been received during the year have been referred to the various standing committees or the Council and have been disposed of. This indicates active,

* (Note: At the Council meeting Dr. Hauss amended the above paragraph by adding, "At the discretion of the president this work be assigned to a special committee, or to one of the standing committees." See minutes of The Council).

working committees, and shows the great spirit of this great association of ours.

Unfinished Business

Change in Section 4, Article IX, of Constitution. On motion of Drs. Kennedy and Duemling, the following section, changing the method of electing councilors, was adopted to replace Section 4, Article IX, of the Constitution, which is to be deleted:

> *Sec. 4.* The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

New Business

1. *Certification of members for honorary membership in the state association.* The chairman read Article IV, Section 5, of the Constitution of the state association, which states:

> Honorary members shall consist of representative teachers and students of science allied to medicine and of physicians and surgeons of distinction not members of the Indiana State Medical Association, who may by vote of the House of Delegates be elected to honorary membership; *and any physician of the State of Indiana who has attained the age of seventy-five years and has held membership in the Indiana State Medical Association for twenty years or more may be elected to honorary membership by vote of the House of Delegates, provided his name be proposed for such honorary membership by the county medical society of which such physician is a member.*

Dr. Black moved that the nominations for honorary members be presented to the executive secretary on the form supplied by the headquarters office and that these nominations be approved by the House en masse rather than by each individual county. Motion duly seconded and carried. These nominations were referred to the Reference Committee on Miscellaneous Business.

2. *Supplementary report of Chairman of Council.* Dr. Alfred Ellison read the following resolutions which had come to the attention of the Council:

a. *Resolution originated by the Clinton County Medical Society and endorsed by the Ninth District Medical Society at its meeting on May 15, 1947:*

The Clinton County Medical Society hereby declares itself in wholehearted approval of the following:

(1) That the State Medical Association, in conjunction with the State Board of Medical Registration under the laws of the state be empowered to accredit hospitals for internship within the state.

(2) That the system of American boards be abandoned except as representing voluntary membership.

(3) Withdrawal of the American College of Surgeons or other organizations from a position of control of staff membership of any hospital in our state and further, from control of any and all operation procedures within the hospitals of our state, withdrawing to a position of consultations on request and eliminating entirely any taint of compulsion.

(4) Immediate restoration of the county medical society to the basis of organization of the profession.

(5) Reaffirmation of adherence to the ethics, morals and dignity of our profession and a determination to deny any and all future movements that lead to any form of compulsion other than the continuance of the high aim that has been our past history.

(Referred to Reference Committee on Medical Education and Hospitals.)

b. *Resolution on Medical Ethics.*

WHEREAS, Small county hospitals are increasing in number; and

WHEREAS, Inadequate pathological service is likely to be the rule; and

WHEREAS, Increasing participatioin in prepayment insurance plans will increase hospitalization and surgery, and

WHEREAS, These above factors will tend to increase unnecessary hospitalization and surgery and

WHEREAS, Local hospitals and county societies may not be able or willing to control these unnecessary practices which are a detriment to the profession at large,

Be It Resolved, (1) That a special committee be appointed by the president on advice of the Council to investigate and reprimand offenders who are guilty of such practices; (2) That these procedures be of a secret nature unless such offender or offenders refuse to co-operate in the interests of the profession at large, and (3) That the constitution be so amended to make this committee possible.

(Referred to Reference Committee on Miscellaneous Business.)

c. *Resolution regarding Study of Cost of Training School Operation.*

Be It Resolved, That the Indiana State Medical Association join with the Indiana State Nursing Association and the Indiana Hospital Association in the study of cost of Training School operation as set forth in the resolution adopted by the Indiana Hospital Association.

(The resolution adopted by the Indiana Hospital Association, September 23, 1947, follows:

"That the Indiana Hospital Association request the Indiana State Nurses' Association and the Indiana State Medical Association to join with it in authorizing the Joint Committee of the Indiana State Nurses' Association and the Indiana Hospital Association to make a study of the operating costs of the training schools for nurses in Indiana, such a study to include information as to

a. The time student nurses spend in classes,

b. The time student nurses spend in practice as a part of their training,

c. The actual time spent in work which actually is beneficial to the hospital, and

"That all information derived from such a study shall be made available to the representatives of the three associations for their joint consideration and use for the purposes of improving the program of training students in nursing in Indiana, and

"That the necessary costs of such a study, if any, be borne one-third by each association; and if the results of such a study should warrant legislative procedure, such procedure shall be mutually agreed upon and promoted by the three said associations.")

(Referred to Reference Committee on Medical Education and Hospitals.)

3. *Resolutions from the Lake County Medical Society, presented by Dr. H. W. Eggers, Hammond:*

a. *Regarding hospital staff membership:*

WHEREAS, great concern is being felt by the general practitioner relative to his standing in or appointment to hospital staffs, and

WHEREAS, certain hospitals have inaugurated as a matter of policy limitation of their staff appointments to physicians certified by specialty boards or holding membership in certain special medical societies, and

WHEREAS, this policy is in conflict with the resolution of the House of Delegates of the American Medical Association passed at San Francisco in 1946,

Be It Hereby Resolved, that the House of Delegates of the Indiana State Medical Association protest the limitation of staff membership to only physicians who are members of specialty boards or special medical societies, and

Be It Further Resolved, that hospital staff membership should not be dependent on special certification but rather upon the true worth of the physician to the community which he serves and which the hospital serves.

(Referred to Reference Committee on Medical Education and Hospitals.)

b. *Regarding recognition of the American Academy of General Practice:*

WHEREAS, there was created at Atlantic City in June, 1947, the American Academy of General Practice for the purpose of promoting high standards of general practice of medicine and surgery; encourage postgraduate study for general practitioners; further encourage young men and women to prepare, qualify and establish themselves as general practitioners and to protect the rights of general practitioners to engage in medical and surgical procedures for which they are qualified, therefore

Be It Resolved, that the House of Delegates of the Indiana State Medical Association, by resolution, recognize the American Academy of General Practice and support it in its efforts to create high standards and bring recognition to the large number of men in the general practice field.

(Referred to Reference Committee on Miscellaneous Business.)

4. DR. E. R. CLARKE, Kokomo, introduced the following resolution which was passed by the Howard County Medical Society at its September meeting to be presented to the Indiana State Medical Association at the annual session.

In view of the multiplicity of various health agencies and organizations, each with their separate staff and overhead, it is the opinion of this organization that any such groups now existent or to be formed should clear with and be administered by a co-ordinating group or committee of the State Medical Association.

This is becoming more and more necessary in view of the increasing tendency to form such health agencies and to put first one disease and then another into a separately controlled group, dominated by a lay chairman and board of trustees.

Eventually, the public is going to react unfavorably to these recurring drives for funds. We now have such annual drives in behalf of tuberculosis, poliomyelitis, crippled children, and cancer, and organizations exist for many other special groups, such as diabetes, the hard of hearing, heart disease, arthritis, venereal disease, and multiple sclerosis.

It is our opinion that the practice of medicine should be retained by or returned to the doctors and that any lay efforts should work with the medical societies. In other words, let us not "permit the tail to wag the dog."

Be it therefore resolved, that it is the opinion of this society that a committee be appointed to co-ordinate and control such activities.

(Referred to Reference Committee on Hygiene and Public Health.)

5. *Resolution creating Section on Obstetrics and Gynecology.* Dr. Dudley A. Pfaff, Indianapolis, presented the following resolution:

WHEREAS a great number of physicians over the State feel that the best interest of the state's associated members would be enhanced if the obstetricians and gynecologists and general practitioners engaged in these specialties have the privilege of meeting in a section at the annual State Meeting each year; and

WHEREAS, such a provision would benefit basically the public weal by further promoting maternal welfare and the care of womanhood in general; and

WHEREAS these two important specialties would more properly be recognized as a single specialty, and the public thereby better served; and

WHEREAS such recognition of the two specialties would assist in maintaining the two departments jointly in our State University and various hospitals throughout the state; and

WHEREAS such a section would further stimulate the teaching of the unity of the two specialties; and

WHEREAS the undersigned physicians have been practicing in whole or in part the specialties of obstetrics and gynecology for a varying number of years; and

WHEREAS those whose signatures are herewith appended are licensed to such practice of medicine in the State of Indiana, are members of their respective county societies, and through them, of the Indiana State Medical Association; therefore

Be it resolved that we, the undersigned, petition and pray that the House of Delegates of the Indiana State Medical Association grant to us, as our inalienable right, the privilege of organizing a Section on Obstetrics and Gynecology wherein we may meet to discuss the social and economic features relating to and wherein we may present scientific data pertinent to the specialties of obstetrics and gynecology; and

Be it further resolved that the following amendment be made to the present Constitution and By-Laws of the State Association, to wit:

"Chapter III" of the By-Laws, entitled "Sections," to read as follows:

"Section I—During the Annual Session, the Association may meet in the following Sections:

a. Surgical
b. Medical
c. Eye, ear, nose and throat
d. Anesthesia
e. Obstetrics and gynecology
f. Any other Sections that hereafter may be provided for by the House of Delegates.

(Signed by C. O. McCormick, M.D., and 276 others.)

(Referred to Reference Committee on Sections and Section Work and Reference Committee on Amendments to Constitution and By-Laws.)

5. DR. JOHN R. FRANK, Valparaiso, introduced the following resolution:

Resolved that the following letter be sent by the state association to each member of the Indiana State Legislature:

"The House of Delegates of the Indiana State Medical Association wishes to express its sincere appreciation to the members of the Senate and House in the last legislative assembly for the number of health and hospital bills passed by them of interest to the medical profession and of great benefit to the citizens of our state.

"As a token of this appreciation, we, the delegates assembled, hereby recommend to the Council of the Indiana State Medical Association that appropriate measures be taken to send to each member of the State Legislature, each year, an annual subscription to *Hygeia*, our national health magazine."

(Referred to Reference Committee on Public Policy and Legislation.)

No further business appearing, the House of Delegates adjourned, to meet again at 11:30 a.m., Thursday, October 30, 1947, in the west dining room of the French Lick Springs Hotel.

HOUSE OF DELEGATES

(French Lick Session, 1947)

Second Meeting

The second meeting of the House of Delegates, a luncheon meeting, was held October 30, 1947, in the west dining room of the French Lick Springs Hotel, at 11:30 a.m., with the president, Dr. Floyd T. Romberger, presiding.

It was taken by consent that attendance slips signed by the delegates, showing the following present, should constitute the roll call:

County	*Delegates*
Adams	Ben Duke, Decatur
Allen	M. B. Catlett, Fort Wayne
	Arnold H. Duemling, Fort Wayne
	Maurice E. Glock, Fort Wayne
	H. Vaughn Scott, Fort Wayne
Bartholomew	J. E. Dudding, Hope
Benton	V. L. Turley, Fowler
Carroll	C. L. Wise, Camden
Cass	E. B. Jewell, Logansport
Clark	E. P. Buckley, Jeffersonville
Clay	J. F. Maurer, Brazil
Clinton	C. D. Holmes, Frankfort
Dearborn-Ohio	J. K. Jackson, Aurora
Decatur	Boyd L. Mahuron, Greensburg
DeKalb	Charles Weirich, Butler
Delaware-Blackford	O. A. Hall, Muncie
	Gerald S. Young, Muncie
Dubois	G. A. Held, Jasper
Elkhart	A. C. Yoder, Goshen
Fayette-Franklin	F. B. Mountain, Connersville
	H. N. Smith, Brookville
Floyd	William H. Garner, New Albany
Fountain-Warren	Lee Maris, Attica
	Lowell R. Stephens, Covington
Gibson	Virgil McCarty, Princeton
Grant	W. W. Ayres, Marion
Greene	M. S. Mount, Bloomfield
Hamilton	John S. Hash, Noblesville
Hancock	J. L. Allen, Greenfield
Harrison	William E. Amy, Corydon
Hendricks	O. T. Scamahorn, Pittsboro
Henry	Walter M. Stout, New Castle
Howard	Elton R. Clarke, Kokomo
Jackson	G. R. Gillespie, Brownstown
Jasper-Newton	Richard Schantz, Remington
Jay	George V. Cring, Portland
Jefferson	Jackson W. Modisett, Madison
Jennings	D. W. Matthews, North Vernon
Johnson	O. A. Province, Franklin
Knox	Virgil C. McMahan, Vincennes
Kosciusko	Dan Urschel, Mentone
Lake	J. Robert Doty, Gary
	H. W. Eggers, Hammond
	Ray Elledge, Hammond
	C. M. Jones, Whiting
	J. P. Vye, Gary
Lawrence	Claude Dollens, Oolitic
Madison	C. V. Rozelle, Anderson
	G. B. Wilder, Anderson
Marion	Otto H. Bakemeier, Indianapolis
	James F. Balch, Indianapolis
	Eugene F. Boggs, Indianapolis
	R. M. Dearmin, Indianapolis
	Murray DeArmond, Indianapolis
	E. W. Dyar, Indianapolis
	Bert E. Ellis, Indianapolis
	Roy A. Geider, Indianapolis
	E. V. Hahn, Indianapolis
	Foster J. Hudson, Indianapolis
	Harry E. Kitterman, Indianapolis
	Marlow W. Manion, Indianapolis
	Dudley A. Pfaff, Indianapolis
	Frank B. Ramsey, Indianapolis
	Dan E. Talbott, Indianapolis
	Charles F. Thompson, Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	Fred R. Malott, Converse
Montgomery	J. M. Kirtley, Crawfordsville
Morgan	R. W. VanBokkelen, Mooresville
Noble	C. E. Munk, Kendallville
Orange	Clarence E. Boyd, West Baden Springs
Owen-Monroe	William A. Karsell, Bloomington
Parke-Vermillion	C. Harstad, Rockville
Porter	John R. Frank, Valparaiso
Pulaski	Charles E. Linton, Medaryville
Putnam	F. R. Dettloff, Greencastle
Ripley	L. H. Hopkins, Versailles
Rush	Melvin H. Denny, Rushville
St. Joseph	Erwin Blackburn, South Bend
	F. R. Nicholas Carter, South Bend
	Josephine F. Murphy, South Bend
Shelby	Roger F. Whitcomb, Shelbyville
Spencer	John C. Glackman, Jr., Rockport
Sullivan	C. F. Briggs, Sullivan
Switzerland	L. H. Bear, Vevay
Tippecanoe	Raymond Calvert, Lafayette
	Gordon A. Thomas, Lafayette
Tipton	S. M. Cotton, Goldsmith
Vanderburgh	Paul D. Crimm, Evansville
	C. C. Herzer, Evansville
	Minor Miller, Evansville
Vigo	A. W. Cavins, Terre Haute
	M. C. Topping, Terre Haute
Wabash	G. W. Seward, North Manchester
Warrick	W. C. Stover, Boonville
Washington	L. W. Paynter, Salem
Wayne-Union	W. A. Thompson, Liberty
	Harry P. Ross, Richmond
Wells	Truman E. Caylor, Bluffton
White	H. B. Gable, Monticello
Whitley	B. F. Pence, Columbia City

Councilors

1st District—I. C. Barclay, Evansville
3rd District—A. P. Hauss, New Albany
4th District—Charles Overpeck, Greensburg
6th District—W. U. Kennedy, New Castle
7th District—C. J. Clark, Indianapolis
8th District—E. H. Clauser, Muncie
10th District—W. H. Howard, Hammond
11th District—C. S. Black, Warren
12th District—Paul A. Garber, South Whitley
13th District—Alfred Ellison, South Bend

Past Presidents

W. H. Stemm, North Vernon
W. R. Davidson, Evansville
Charles N. Combs, Terre Haute
G. R. Daniels, Marion
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
R. L. Sensenich, South Bend
Herman Baker, Evansville
E. M. VanBuskirk, Fort Wayne
K. R. Ruddell, Indianapolis
A. M. Mitchell, Terre Haute
M. A. Austin, Anderson
C. H. McCaskey, Indianapolis
J. T. Oliphant, Farmersburg
N. K. Forster, Hammond
J. E. Ferrell, Fortville

Officers

Floyd T. Romberger, Lafayette, president
Cleon A. Nafe, Indianapolis, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
W. L. Portteus, Franklin, Executive Committee member
Albert Stump, Indianapolis, attorney for Association
Thomas A. Hendricks, Chicago, executive secretary emeritus
Ray E. Smith, Indianapolis, executive secretary

Delegates to A.M.A.

Don F. Cameron, Fort Wayne
H. G. Hamer, Indianapolis
Norman M. Beatty, Indianapolis, alternate

Guest

R. L. Rutledge, Alliance, Ohio, president, Ohio State Medical Association.

Election of Officers

Election of officers resulted as follows:

*President-elect, 1948*_____Augustus P. Hauss, New Albany

*Treasurer*_____A. F. Weyerbacher, Indianapolis

*Delegates to A.M.A., for term expiring December 31, 1949*__Wm. M. Cockrum, Evansville
F. S. Crockett, Lafayette

*Alternates*_____Norman M. Beatty, Indianapolis
A. M. Mitchell, Terre Haute

Dr. Augustus P. Hauss: Mr. President, Members of the House of Delegates of the Indiana State Medical Association: I hope that you do not expect much of me at this moment. I have never known a time when my legs trembled as much, and when I had as big a lump in my throat. For many years I have served in the ranks of the Indiana State Medical Association. I have loved this association. I have loved the friends I have made, and the great work that you have done. I have always been happy and satisfied to serve in the ranks. I have sat in this House of Delegates and on the side lines, and I have learned to know this as the world's greatest deliberative body, and now I recognize it as the most unpredictable body. What you have done here today I gratefully recognize as a great honor, but I cannot accept it as just an honor. I will be more happy if I can accept it as another job to be done, as a further assignment to duty, and as a call to work for American Medicine and the Indiana State Medical Association. Gentlemen, I thank you and thank you and thank you. I will need all of your co-operation and all the help that I can get. There are a lot of things to be done that are very important, and as your president and president-elect I shall not represent Floyd County or the Third District, but all the state, and there will be no preferences or no favoritism shown to any one district or any individuals. I hope I have the privilege and the pleasure of serving all of you. I thank you. (Applause.)

Place of Meeting

On invitation of the Marion county delegation, the 1948 and 1949 annual sessions will be held in Indianapolis.

Election of Councilors

First District
Herman T. Combs, Evansville
Fourth District
O. A. Turner, Madison
Seventh District
Election to be held December 9
Tenth District
William H. Howard, Hammond, re-elected
Thirteenth District
Election to be held November 12

REPORTS OF REFERENCE COMMITTEES

Sections and Section Work

House of Delegates,
Indiana State Medical Association.
Gentlemen:

The program arranged by the Committee on Scientific Work is excellent and your Committee on Sections and Section Work congratulates the members of this committee.

The scientific exhibit is very interesting and highly instructive, and Dr. J. L. Arbogast and his committee are to be commended on their efforts.

The question of a Section on Industrial Medicine was considered but it was the opinion of the committee that this should be incorporated as a part of the General Practice Section. It was moved by Dr. Young, seconded by Dr. Pence,* that we do not have a Section on Industrial Medicine. It was recommended that this program be carried on in the General Practice Section.

The question of a Section on Diseases of the Chest was discussed. It was moved by Dr. Young that we do not have a section on Chest Diseases. Seconded by Dr. Talbott.* An amendment was made that this group be represented by a paper or speaker on the General Practice program.

The question of a Section for Obstetrics and Gynecology was considered and motion made by

Dr. Young, seconded by Dr. Calvert, that a Section on Obstetrics and Gynecology be created.

These recommendations are made by your Reference Committee on Sections and Section Work subject to the approval of the House of Delegates.

C. S. Black, M.D., *Chairman*
Foster J. Hudson, M. D.
R. R. Calvert, M.D.
Gerald S. Young, M.D.
Charles E. Gillespie, M.D.

* Members of Reference Committee on Amendments to Constitution and By-Laws.

Dr. Black: The consensus of opinion was that we are getting overloaded with sections and that it would be nice if we could have a unity session with speakers selected by each of the sections, and everybody meet in one unit for one year and try it out.

(On motions, duly seconded and carried, this report was adopted by sections and as a whole.)

Rules and Order of Business

Nothing having been referred to this committee, there was no report.

Medical Education and Hospitals

House of Delegates,
Indiana State Medical Association.
Gentlemen:

Your Reference Committee on Medical Education and Hospitals has considered the following matters referred to it by the House of Delegates: The report of the Committee on Medical Education and Hospitals; the report of the Committee on Medical and Nursing School Scholarships; the report of the Instructional Course Committee; the report of the Committee on Study of Undergraduate Medical Education; the Clinton County resolution; the Lake County resolution regarding hospital staff membership; the resolution regarding the study of cost of training school operation; and the reference committee submits an additional resolution, which was arrived at out of its deliberations. We move the acceptance of the reports of the Committee on Medical Education and Hospitals, the Committee on Medical and Nursing School Scholarships and the Instructional Course Committee, as printed in the Handbook. (Motion duly seconded, and carried.)

The report of the Committee on Study of Undergraduate Medical Education is accepted as read with the exception of paragraph No. 7 which is changed to read as follows:

"7. That in view of the complexity of the problems confronting all schools of medicine and the medical profession in reference to graduate medical education and with particular regard for the situation in our own state, it is recommended that the standing Committee on Medical Education and Hospitals of the Indiana State Medical Association conduct continued and prolonged studies, and that the findings and recommendations of this committee be reported at stated intervals to the Council of the State Medical Association and annually to the House of Delegates."

(Motion for adoption of this section seconded by Dr. Carter, and carried.)

Your reference committee has studied the resolutions from Clinton and Lake counties and offer the following resolution in their place:

"Resolved, That the attainment and maintenance of high standards of hospital care, in the interest of safeguarding the life, health, and welfare of the patient, demand rules and regulations fixing the minimum qualifications physicians and surgeons must have for admission into hospitals to render the types of service needed by their patients; that this Association encourages any efforts to improve the standards of care; and that it is the judgment of this Association that all such rules and regulations pertaining to admission of physicians into hospitals should be on the basis of the kind and amount of training received and the professional interest manifested, and not on the basis of membership on any board or other special group of physicians.

"Resolved further that the work being done by the State Hospital Council in helping to formulate rules and regulations for adoption by hospital boards, is commended and approved by this Association."

(Motion for adoption of this resolution seconded by Dr. Catlett, and carried.)

Your reference committee approves and recommends the adoption of the following resolution:

"Be It Resolved that the Indiana State Medical Association join with the Indiana State Nursing Association and the Indiana State Hospital Association in the study of cost of Training School operation as set forth in the resolution adopted by the Indiana State Hospital Association."

(Motion for adoption seconded by Dr. Clark, and carried.)

The implementation of the Hospital and Construction Act in Indiana has developed the need for an extensive program of education of both lay and medical groups in the communities where the hospitals are to be constructed.

The lack of interest in smaller county medical societies stems largely from lack of adequate programs. Properly many of these smaller medical societies with similar economic and social problems could be grouped for the purpose of graduate educational instruction and discussion of their economic and community problems.

Effective so-called public relations begins and ends in "the doctor himself"—his relations with the patient—the community and its various agencies for welfare—community betterment, etc., etc. No amount of money or effort expended at the state or national levels can overshadow purely local effort.

These problems and many others are being met in some states, notably Missouri and Colorado, by the employment of field secretaries. Your committee recognizing these needs and with the feeling that organized medicine has the obligation to do something about them, offers the following resolution:

Resolved, That the permanent Committee on Medical Education and Hospitals be instructed to study the

matter of employment of a field secretary or secretaries and report its findings to the Council, and

Be It Further Resolved, That this House of Delegates empower the Council to take such action as it may deem proper and wise in regard to the report of the Committee on Medical Education and Hospitals.

(Motion for adoption of this section of the report seconded by Dr. Combs, and carried.)

We move the adoption of this report as a whole.

HERMAN M. BAKER, M.D., Chairman
ROY A. GEIDER, M.D.
ROBERT M. DEARMIN, M.D.
F. R. N. CARTER, M.D.
C. V. ROZELLE, M.D.

(Motion seconded by Dr. Duemling, and carried.)

Public Policy and Legislation

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Reference Committee on Public Policy and Legislation met on October 29, considered the various matters referred to it, arrived at unanimous conclusions, and begs to report as follows:

1. *Report of the Committee on Public Policy and Legislation.* This committee recommends approval of the first, second and third paragraphs of the report of the Committee on Public Policy and Legislation as printed in the Handbook, with appreciation of their magnificent work in covering the legislative field. (Motion for adoption of this section of the report seconded by Dr. Daniels, and carried.)

This committee recommends that the paragraph of the report of the Committee on Public Policy and Legislation under the caption of "Registration Law" be approved by the House of Delegates and that the House of Delegates specifically endorse the action of the Association's officers and the Council in agreeing to a compromise registration fee of $5.00 per annum. (Motion for adoption of this section of the report seconded by Dr. Scamahorn, and carried.)

This committee recommends approval of the paragraphs of the report under the captions, "Physicians Should Be Legislators" and "Federal Legislation." (Motion carried for adoption of this section of the report.)

2. *Report of Committee on Civic and Industrial Relations.* This committee took due cognizance of the report of the Committee on Civic and Industrial Relations and has no further recommendations to make. (Motion carried for adoption of this section.)

3. *Report of the Committee on Public Relations.* This committee recommends hearty endorsement of the last paragraph of the report of the Committee on Public Relations as published in the Handbook, said paragraph emphasizing the importance of satisfactory medical service for the maintenance of good public relations. This committee, however, questions whether the opinion of the Committee on Public Relations respecting the alleged lack of interest in a program of postgraduate medical instruction is well based in fact. This committee further believes that where lack of interest in postgraduate instruction is known to exist, the Indiana State Medical Association should endeavor to stimulate such interest to the end that the high aims expressed in the last paragraph of the committee's report may be furthered and achieved.

This committee recommends that these questions be referred again to the Committee on Public Relations for further fact-finding and appropriate action.

We move the adoption of this part of our report. (Motion seconded by Dr. Doty, and carried.)

4. *Report of Committee on Maternal and Child Health.* With respect to the report of the Committee on Maternal and Child Health, this committee reports as follows:

(1) We note with approval and move acceptance by the House of Delegates of those parts of the report which summarize the results of an admirable work of fact-finding. (Motion duly seconded, and carried.)

(2) With respect to the resolution on page 71 of the Handbook, "that the State Board of Health continue to provide medical and hospital care for unmarried mothers and children born out of wedlock," this committee believes that such questions should be given careful consideration by the standing committee on Public Relations and recommends that the House of Delegates refer this resolution to that committee for a report to the House of Delegates in 1948. (Motion carried for adoption of this section of the report.)

(3) With respect to the resolution requesting the establishment or expansion of institutions for the care of mentally defective children under six years of age, this committee believes that this expansion is already provided for by the legislative act of 1947 creating the Indiana Council for Mental Health and establishing the Larue D. Carter screening hospital. This committee therefore recommends that no action be taken by the House of Delegates in this matter. (Motion for adoption seconded by Dr. Catlett, and carried.)

(4) With respect to the resolution on page 73, section 3, that blood plasma supplied by the State Board of Health shall be earmarked for obstetrical emergencies, it is the opinion of this reference committee that the administrative details of the State Board of Health cannot properly be subject to the control of the House of Delegates. The committee therefore advises that no action be taken. (Motion for adoption of this section seconded by Dr. Doty, and carried.)

(5) With respect to the terminology advocated by the Committee on Maternal and Child Health relative to definitions for abortion, early and late premature delivery, and stillbirth, this committee recommends approval of the terminology as suggested in the above report on page 74 of the Handbook. (Motion for adoption of this section seconded by Dr. Crockett, and carried.)

(6) With respect to the resolution on page 75, under section 5, to the effect that the Indiana University Medical School should be urged to establish a special center for demonstration and teaching of the problems of premature birth, this committee is of the opinion that the school can be trusted to include in its curriculum adequate coverage of this subject. We therefore recommend that no action be taken hereon by the House of Delegates. (Motion carried for adoption of this section.)

5. *Report of Liaison Committee of the Division of Services for Crippled Children.* This committee took cognizance of the fact that the Committee of the Division of Services for Crippled Children had not been active during the year, had made no report, and this committee has no recommendations to make under this heading. (Motion for adoption of this section seconded by Dr. Duemling, and carried.)

6. *Report of Committee on Rural Medical Care.* This committee pondered the report of the Committee on Rural Medical Care and the supplemental report read before the House of Delegates on October 28, and it recommends that the House of Delegates authorize the president of the Indiana State Medical Association and the Council to take such steps as may be necessary to lend strength and implementation to the cause of rural medical care. (Motion for adoption of this paragraph seconded by Dr. Crockett, and carried.)

7. *Resolution proposed by Executive Committee and read before the House of Delegates on October 28.* This committee recommends that the motion of the Executive Committee adopted October 27, 1947, be approved by the House of Delegates in the following form: "That the Association sponsor legislation in the next General Assembly to the following effect:

(1) That it shall be illegal for anyone to apply to himself the title 'Doctor' unless such doctor's degree has been conferred by a recognized educational institution.

(2) That it shall be illegal for a doctor to use the title 'Doctor' without also using the abbreviated suffix designating the kind of doctorate he holds." (Motion for adoption of this resolution seconded by Dr. Duemling, and carried.)

8. *Resolution introduced by Dr. J. R. Frank.* This committee recommends approval of the proposal that a letter of appreciation be sent by the Indiana State Medical Association to all members of the 1947 session of the Indiana General Assembly for their support of the measures in the interest of public health and of the medical profession. (Motion for adoption of this resolution seconded by Dr. Duemling, and carried.)

This committee recommends that the House of Delegates authorize the executive secretary to send *Hygeia* to each member of the Indiana General Assembly for the period of his term of office as a measure for bringing to his attention sound general medical information. (Motion carried for adoption of this section.)

E. Vernon Hahn, M.D., *Chairman*
Will A. Thompson, M.D.
J. R. Doty, M.D.
J. Frank Maurer, M.D.
C. D. Holmes, M.D.

(Motion carried for adoption of this report as a whole.)

Publicity

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee on publicity has been handed the following reports: report of the Bureau of Publicity, report of the Committee on Centennial Celebration, and the report of the State Fair Committee.

We wish to commend the members of the Bureau of Publicity for the enormous volume of work they have done during the past year and for their splendid efforts on behalf of the state medical association, and commend the record published in The Journal to the diligent attention of all members. We recommend the adoption of the report with the association's thanks. (Motion seconded by Dr. Ferrell, and carried.)

The Committee on Centennial Celebration has done, and certainly in the future will be called upon to do more work than any other committee of the state medical association. We wish to commend this committee for its efforts and encourage it in its future endeavors. We recommend the adoption of this report as published in The Journal, with a recommendation of a vote of thanks to each individual member. (Motion seconded by Dr. Catlett, and carried.)

The committee also wishes to recommend the acceptance of the report of the Committee on State Fair. The Reference Committee realizes that each individual member of the Committee on State Fair has put forth a tremendous amount of work and effort at great personal sacrifice, and we wish to commend them for their splendid efforts and the results as published in the Handbook.

It has been brought to the attention of the reference committee that there are certain problems in sanitation and water supply at the State Fairgrounds which are not at the optimum level of

hygienic standards. We would recommend that the House of Delegates bring to the attention of the Lieutenant-Governor and the State Fair Board these conditions and that the state association offer its services in assisting in the correction of such conditions. We recommend the adoption of the State Fair Committee report as published in the Handbook. (Motion seconded by Dr. Black, and carried.)

BERT E. ELLIS, M.D., *Chairman*
LEE MARIS, M.D.
IRVIN E. HUCKLEBERRY, M.D.
HARRY P. ROSS, M.D.
E. E. PADGETT, M.D.

(Motion for adoption of report as a whole carried.)

Hygiene and Public Health

House of Delegates,
Indiana State Medical Association.

Gentlemen:

1. *Report of Committee on Mental Health.* Your reference committee, after studying this report, moves its adoption as printed in the Handbook on page 66. (Motion, seconded by Dr. Duemling, carried.)

2. *Report of Committee on Control of Cancer.* Your committee, after studying this report, compliments the standing committee on its review of the present standing of the various cancer organizations in the state and recommends the adoption of the committee's recommendations 1, 2, 4 and 5, and 3 up to the word "emphasis," and deleting the rest of the paragraph and inserting, "but the emphasis should be given to aid in cancer control rather than in utilization of federal funds under federal regulations."

(Here Dr. Garner read paragraph 3 of the Cancer Committee's report as follows and explained that it was the consensus of opinion of the reference committee that it didn't want to come out as endorsing emphasis on the utilization of federal funds:

"3. That the cancer teaching program to undergraduates in medical and dental school be given greater emphasis in order to utilize federal funds available for that purpose.")

(Motion for adoption of this section, as amended, carried.)

3. *Report of Committee on Venereal Disease.* Your committee, after studying the report in the Handbook and the supplementary report believes the reports to be very educational and compliments the committee on its excellent work. We move the adoption of these reports, with the addition of the following words in recommendation No. 4: "A second blood test after an interval of at least a week." (Motion for adoption of this section carried.)

4. *Report of Committee on Industrial Health.* After studying the report of the Committee on Industrial Health, as printed in the Handbook on page 84, we recommend its adoption as printed, with the exception of the part referring to a special section, which was referred to the Reference Committee on Sections and Section Work for action. (Motion seconded by Dr. Duemling, and carried.)

5. *Report of Anti-Tuberculosis Committee.* After studying this report we recommend its adoption with exception of the part referring to the creation of a Section on Diseases of the Chest, which was referred to the Reference Committee on Sections and Section Work. (Motion for adoption seconded by Dr. Black, and carried.)

6. *Report of Committee on Conservation of Vision.* Your committee, after studying the report of the Committee on Conservation of Vision, compliments the members of this committee on their work and recommends the adoption of this report as printed in the Handbook on page 91. (Motion for adoption seconded by Dr. Duemling, and carried.)

7. *Report of Committee on Hard of Hearing.* Your committee regrets that no constructive work was done by this committee. However, we move the adoption of this report as printed in the Handbook. (Motion seconded by Dr. Duemling, and carried.)

8. *Resolution passed by the Howard County Medical Society.* It is the opinion of this committee that the correlation of health agencies and of activities of organized medicine is of prime importance, in order to prevent the overlapping of services of lay, state and federal organizations. We feel, however, that this does not require formation of a new committee but it can be administered by the present standing Committee on Public Policy and Legislation and we urge the delegation of the work to this committee. (Motion for adoption of this section seconded by Dr. Duemling, and carried.)

We move the adoption of this report as a whole. (Seconded by Dr. Catlett, and carried.)

WILLIAM H. GARNER, M.D., *Chairman*
TRUMAN E. CAYLOR, M.D.
M. C. TOPPING, M.D.
PAUL D. CRIMM, M.D.
J. K. JACKSON, M.D.

Amendments to Constitution and By-Laws

House of Delegates,
Indiana State Medical Association,

Gentlemen:

Your reference Committee on Amendments to Constitution and By-Laws recommends the following change in Chapter III of the By-Laws, entitled "Sections," to read as follows:

"Section 1.—During the Annual Session the Association may meet in the following sections:

a. Surgical.
b. Medical.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. Obstetrics and Gynecology.
f. Any other sections that hereafter may be provided for by the House of Delegates."

(Motion for adoption of this section of the report seconded by Dr. Catlett, and carried.)

Your Reference Committee on Amendments to Constitution and By-Laws recommends that machinery be set up to include in the official family a vice-president, a speaker of the House, and that the selection of the convention city be made two years in advance.

(Motion for adoption of this section carried.)

GORDON A. THOMAS, M.D., *Chairman*
B. F. PENCE, M.D.
G. L. VERPLANK, M.D.
A. W. CAVINS, M.D.
DAN E. TALBOTT, M.D.

(Motion for adoption of the report as a whole seconded by Dr. Duemling, and carried.)

Reports of Officers

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your reference committee, to which were referred the reports of officers, submits the following:

President's Address

Your reference committee wishes to commend most highly the exhaustive report on the "State of Our Association" by our President, Dr. Romberger. All phases of our Association's organization and its activities were reviewed by him and suggestions were made how to maintain and increase the morale and activities of its members.

The report of our President is evidence in itself as to the amount of his time and energy he has given in his devotion to our cause. (Motion for adoption of this section of reference committee's report carried.)

We, the reference committee, realize that changes in our Constitution to provide more officers for our Association, such as Speaker of the House of Delegates and a Vice-President, as recommended by our President, must be decided by this body, the House of Delegates. However, it is the opinion of the reference committee that in the future, as in the past, the attorney of our Association be authorized and directed to act as parliamentarian in all proceedings of the House, thus obviating the need of a speaker. (Dr. Yoder said that this was merely a recommendation.)

Likewise, with respect to the creation of the office of Vice-President, your committee feels that the President-elect is really a Vice-President. Our Constitution stipulates that the President-elect shall assist the President in the discharge of his duties, and shall become President in the event of a vacancy in that office.

To clarify further the order of procedure in the event of vacancies in both the offices of President and President-elect, the committee wishes to suggest an amendment to the Constitution which shall provide that, in the event of vacancies in both offices, the Chairman of the Council become President pro tem, and, as such, shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing men to these vacancies. (Dr. Yoder's motion for adoption of this section of the report duly seconded.)

Discussion

THE PRESIDENT: The Speaker would be elected by the House. The attorney is selected by the Council.

DR. HERMAN BAKER: Mr. President, Gentlemen of the House: Ten years ago I was president of this Indiana State Medical Association. I was out of my town seventy-seven days the year that I was president. This thing is becoming a sort of man-killing job, and I certainly would urge serious consideration be given to the business of a permanent Speaker of the House, to relieve the president of that most arduous duty. I don't know how many of you realize the many, many jobs that this fellow has to do, and each year the association increases in membership. The duties have just become overburdening for any one man to carry. I would certainly urge seriously that you consider this business of a permanent Speaker of the House.

THE PRESIDENT: Let me remind the House that it already has authorized the amendment. This must lay on the table for a year. The motion before the House is the adoption of that part of the report which Dr. Yoder just has made. If it is accepted in the affirmative, then we are going to have a conflict. If it is rejected, then the report of the Reference Committee on Amendments to the Constitution and By-Laws naturally stands. The decision is up to this House.

DR. J. H. WEINSTEIN: I want a point of information. As I get it, there is no formal resolution presented for amendment as yet.

THE PRESIDENT: Not in the case of the report of Dr. Yoder. The other was. That was done on the committee's recommendations. I shall read the report of the Reference Committee on Amendments to the Constitution and By-Laws with regard to the agenda under discussion. (Reads.) That recommendation was adopted by this House. The motion is to set up the machinery.

DR. WEINSTEIN: But we can't adopt that and act upon a motion to amend the constitution next year. It would have to go over, because the formal amendment could not be placed before the House until next year.

THE PRESIDENT: I agree.

DR. J. E. FERRELL: May I ask how this difficulty arose? Was it given to two committees?

THE PRESIDENT: My address was referred to the Reference Committee on Reports of Officers, and that part of the address which pertains to amendments was referred to the Reference Committee on Amendments to the Constitution and By-Laws. Whether or not the Reference Committee on Reports of Officers has the right to make suggestions officially to this House on amendments to the Constitution and By-Laws is open to question.

DR. FERRELL: My opinion is that it was only suggested by you in your speech. It wasn't an active amendment at all. It seems to me that the Committee on Reports of Officers should have this thing in detail.

MR. ALBERT STUMP: Whatever is done in the course of the proceedings of a convention should be governed by the Constitution and By-Laws. Therefore, whatever reference might have been made by the president with respect to the reports of officers should be consistent with the Constitution and By-Laws. The president's address ordinarily is referred to the Reference Committee on Reports of Officers. Yet, under the Constitution and By-Laws, so far as this address suggests any change in the Constitution and By-Laws, that section of the address would be referable to the Reference Committee on Amendments to the Constitution and By-Laws. The president, however, might make a reference with respect to advice that the Reference Committee on Amendments to the Constitution and By-Laws might receive from some other reference committee, but the Constitution and By-Laws of the association still would govern. The action on the report of the Reference Committee on Amendments to Constitution and By-Laws then should be regarded as the final expression of the views of the House on the subject matter of change in the Constitution and By-Laws as contained in the president's address.

DR. WEINSTEIN: I would like to clarify the point that I tried to make, that is, that we have had no formal resolution to amend the constitution and unless that comes this year it cannot be acted upon next year.

MR. STUMP: What Dr. Weinstein says is correct. There has been no formal amendment to the constitution submitted up to this time. There is the recommendation that the machinery be prepared. You do not vote on an amendment in general terms. It must be specific, so that you know exactly what the language is. If there is merely a recommendation that this plan be worked out, that constitutes, in my judgment, a recommendation that there be amendments drawn, to be submitted at a later date; then these amendments would have to stand over the period required in the Constitution and By-laws before they could be acted upon. This recommendation can not stand as a submitted amendment to the constitution, because the exact language isn't there.

THE PRESIDENT: The motion before the House is to adopt the part of the reference committee report as presented by Dr. Yoder.

In order to clarify this the chair is going to ask whether those who voted for the original motion for the adoption of the report of the Reference Committee on Amendments to the Constitution and By-laws wish to reconsider or not. A motion to reconsider, according to Roberts Rules of Order, takes precedence over any other motion. (Reads report of Reference Committee on Amendments to Constitution and By-laws.) Does the House wish to reconsider this, or does the House wish to stand by its original decision?

DR. J. T. OLIPHANT: I move to reconsider this section of the report. (Motion seconded.)

DR. J. R. DOTY: If we do not go on with this now, it is going to delay it another year. If we feel these offices should be instituted, then this motion before the House should be defeated.

THE PRESIDENT: We have two motions before this House, one of which is the main motion by Dr. Yoder, and the other the motion made by Dr. Oliphant to reconsider. The motion to reconsider, if carried, brings before the House the original motion of whether or not the House wishes to stand by its action originally taken.

DR. DOTY: I thought we were voting on the reconsideration. By defeating the motion to reconsider, the original report will stand.

(On voting, the motion to reconsider was lost, as was also Dr. Yoder's motion for acceptance of the section under discussion of the report of the Reference Committee on Reports of Officers.)

Report of Reference Committee on Reports of Officers, Continued

Address of President-elect

We, your committee, wish to thank Dr. Nafe, president-elect, for his very fine portrayal of conditions affecting the profession, both now and in the future. We recommend the adoption of his address as a whole. (Motion seconded, and carried.)

Report of Executive Secretary

If you have read the allegory on page 9 of our Handbook of the good ship "Indiana Medicine" you no doubt have a good idea of the working of the machinery of our state medical association and of what goes on behind the scenes, as well as what happens in the open. Our very able Tommy Hendricks took care of the duties of the executive secretary with great ability. That work has been taken over now by our present secretary, Ray E. Smith. We feel that the duties of that office have been splendidly done and that Ray has not let affairs lag in any manner,—always on the spot whenever needed and giving assistance in a high-class manner. It would require too much time to enumerate his various activities and accomplishments in the short time he has held that office.

We feel sure that any time Ray is called upon to assist any committee of our association in any endeavor, be it in the Legislature or otherwise, you will find him doing it in an efficient manner and with a smile. (Motion for adoption of this section of the report seconded by Dr. Duemling, and carried.)

Treasurer's Report

We wish to commend Dr. Weyerbacher very highly for a very complete and satisfactory treasurer's report and recommend the adoption of his report as published in the Handbook. (Motion seconded, and carried.)

Report of Chairman of the Council

We, your reference committee, approve the report of the chairman of the Council. We especially want to commend highly the action of the awarding of scholarships for medical students and nurses.

We feel that it is very fitting to recognize and honor the physicians who have served for fifty years in the practice of medicine. We recommend the adoption of the report of the chairman of the Council as published in the handbook. (Motion seconded by Dr. Duemling, and carried.)

Report of Executive Committee

We, as reference committee, wish to acknowledge the great amount of work done satisfactorily and wish to commend the Executive Committee for the great service to the medical society.

We recommend the adoption of the Executive Committee's report as published in the Handbook of the House of Delegates. (Motion seconded, and carried.)

Report of Journal Publication Committee

We, your reference committee, wish to commend the staff of THE JOURNAL for a job well done. We feel that we have the best state journal in the country. We also approve of the increase in per capita payment from $2.00 to $3.00. We recommend the adoption of this report as published in the handbook. (Motion seconded, and carried.)

A. C. YODER, M. D., *Chairman*
J. E. FERRELL, M.D.
CLAUDE DOLLENS, M.D.
C. F. BRIGGS, M.D.
JOSEPH E. DUDDING, M.D.

(Dr. Yoder moved the adoption of the report as a whole with the exception of that part having to do with a Speaker and Vice-president, which was covered by another reference committee report. Motion seconded by Dr. Duemling, and carried.)

Committee on Credentials

DR. WILLIAM KARSELL: I have been instructed to move that the House of Delegates accept the report of the standing Committee on Credentials, as printed in the Handbook. (Motion seconded, and carried.)

Miscellaneous Business

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Miscellaneous Business makes the following report:

1. On the report of the Committee on Arrangements, we desire to commend very highly the work of the Committee on Arrangements under the direction of the co-chairmen, Drs. Hauss and Boyd, and the rest of the members of that committee. They have done a splendid job under very adverse conditions and they deserve the highest commendation from this society.

2. This committee feels that the Committee on Secretaries' Conference has done a fine job and its activity has been a very important factor in building up the Indiana State Medical Association. We recommend the adoption of their report and we feel that they are entitled to the thanks of the society for their zeal.

3. The report of the Committee on Necrology and History should be adopted. Under the direction of Doctor Maple, a very careful report of the deaths of members of this society has appeared from month to month in the JOURNAL, and we believe that Doctor Maple is entitled to the thanks of the association. It is unfortunate that no meetings of the Committee on History have been held, and we recommend that this committee be continued for another year.

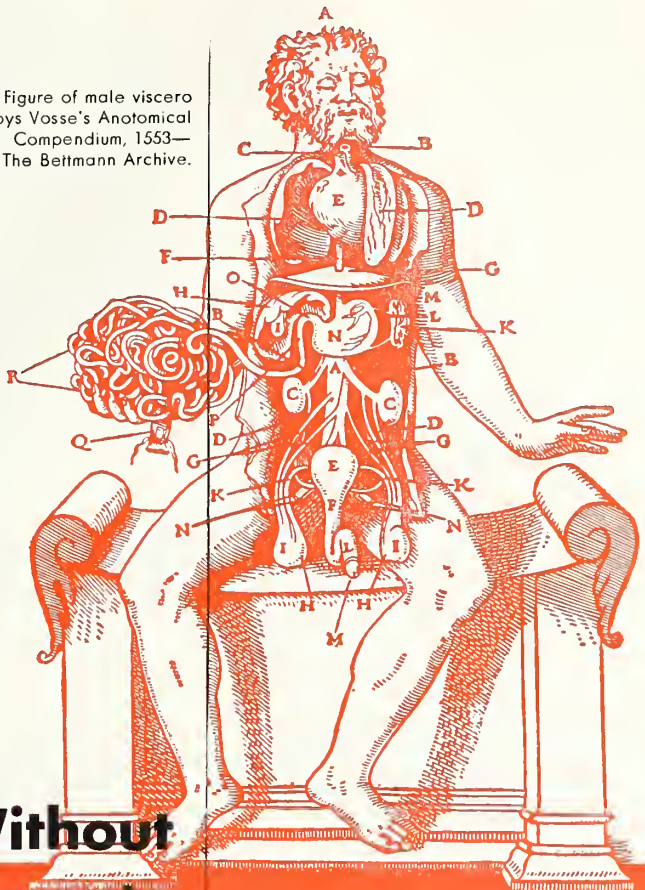
4. We recommend the adoption of the report of the Committee on Inter-Professional Health Council.

5. The report of the Committee on Rehabilitation Services should be adopted. We recommend that this committee be retained and that its work be extended to include all rehabilitation problems confronting returned medical veterans.

6. The report of the Veterans Committee should be adopted. We recommend the continuation of this committee to safeguard the interests of the doctors of Indiana in their dealings with the Veterans Administration. (Dr. Oliphant's motion for adoption of the report up to this point was seconded by Dr. Black, and carried.)

7. The following named physicians, having attained the age of seventy-five, and having held membership in the Indiana State Medical Association for twenty years or more, and having been recommended by the various county medical societies, are entitled to honorary membership in the association. This list has been checked by the office of the executive secretary. We therefore recommend that they be granted honorary membership in the Indiana State Medical Association.

(Dr. Oliphant moved the adoption of this part of the report, without reading the names, as the list was too long. Motion seconded by Dr. Black, and carried.)



Anotomy: Figure of male viscero from Loys Vosse's Anotomical Compendium, 1553— Courtesy, The Bettmann Archive.

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8. Under new business, a resolution on medical ethics was introduced by a member of the Executive Committee of the Indiana State Medical Association. This resolution called for the appointment by the president, on advice of the Council, of a committee to investigate and reprimand certain offenders who might be guilty of unethical practices in local hospitals. We believe that the appointment of such a committee would constitute a dangerous precedent and that the matters to be dealt with lie entirely within the province of the county medical societies. Therefore, we recommend that this resolution not be adopted. (Motion for adoption of this recommendation duly seconded, and carried.)

9. A resolution from the Lake County Medical Society was introduced asking that the House of Delegates of the Indiana State Medical Association, by resolution, recognize the American Academy of General Practice and support it in its efforts to create high standards and bring recognition to the large number of men in general practice. Some two or three years ago the Indiana Board of General Practice was launched under the sponsorship of this society. It is now a going concern and is getting on its feet. Its scope and objectives seem to be similar to those of the Academy of General Practice. Last night Doctor Davis spoke for the Academy of General Practice, but after the meeting there was a sharp division of opinion upon which of these vehicles is better suited to advance the general practice of medicine in Indiana. Until such difference of opinion is more composed, we deem it wise to postpone the adoption of the Lake County resolution. (Motion for adoption of this section of the report carried.)

JACOB T. OLIPHANT, M.D., *Chairman*
CHARLES O. WEDDLE, M.D.
E. P. BUCKLEY, M.D.
ALBERT M. DEARMOND, M.D.
J. M. KIRTLEY, M.D.

(Dr. Oliphant moved the adoption of the report as a whole; motion seconded, and carried.)

DR. M. B. CATLETT: Mr. President, Members: I wish to present a resolution for changes in the constitution, in Article IX, Section 1; that it be amended to read as follows:

> "The officers of this association shall be President, President-elect, Vice President and Speaker of the House, an Executive Secretary, a Treasurer, 13 Councilors, all of whom shall be a member, except the executive secretary, who need not necessarily be either a physician or a member."

Have it read as follows:

> "That the additional officers being the Vice-President and Speaker of the House, having such duties as usually pertain to such offices."

Dr. Ferrell asked if introduction of this resolution at this time wasn't out of order.

MR. STUMP: It must first be presented to the House of Delegates and referred to the proper reference committee. Since the resolution was introduced only today, it can be considered only upon the suspension of the rules, which would take two-thirds of the votes of this House of Delegates. Then it could be voted on at this meeting. Someone could move that the resolution be acted on under a suspension of the rules.

(Motion for suspension of the rules, made by Dr. Duemling and seconded by Dr. Crockett, was lost on standing vote, 42 to 31.)

DR. J. M. KIRTLEY presented the following resolution:

> For many years one of the most prominent figures in the Indiana State Medical Association has been our retiring president, Doctor Floyd T. Romberger. He has been a frequent visitor at the meetings of the County Medical Societies within his own Ninth Councilor District where he has always championed the County Medical Society as the bulwark of organized medicine. As councilor, he gave unstintingly of his time and knowledge of medical affairs and served as chairman of the Council prior to his elevation to the presidency of the Indiana State Medical Association. His many offices and his wide experience qualified him eminently for the leadership of this association during the difficult times through which we are living.
>
> *Therefore, Be it Resolved,* that the House of Delegates of the Indiana State Medical Association here assembled, in behalf of all the members of this association, hereby records its sincere appreciation of the untiring services of Doctor Romberger.

Mr. President, I move you the adoption of this resolution. (Passed by standing vote.)

DR. BERT ELLIS, presented the following resolution:

> WHEREAS, this ninety-eighth session of the Indiana State Medical Association has been a full and complete success from every standpoint, and
>
> WHEREAS, the many and varied arrangements necessary for staging this successful meeting have called for the expenditure of a great amount of time and effort on the part of many persons, and
>
> WHEREAS, a great proportion of this work has fallen upon the shoulders of Dr. A. P. Hauss and Dr. C. E. Boyd, the Orange County Medical Society, the Third District Medical Society, and the Woman's Auxiliary, now therefore
>
> *Be it Resolved* that this assemblage go on record in extending a vote of thanks and congratulations to the individuals and organizations mentioned above and, in addition, to the Press, the officers of the Indiana State Medical Association, the headquarters staff of the Indiana State Medical Association, and the French Lick Springs Hotel, for assuring the success of the 1947 meeting.

(Motion for adoption seconded, and carried.)

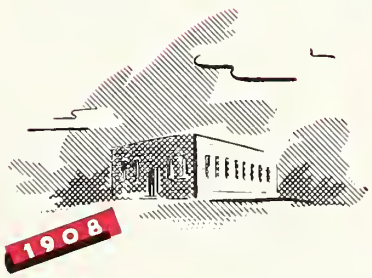
DR. KARSELL: In compliance with the suggestion of the president in his talk yesterday, I move that the House of Delegates of the Indiana State Medical Association go on record as urging the naming of the building in the I. U. Medical Center in honor of Dean Emeritus Burton D. Myers. (Motion seconded by Dr. Frank, and carried.)

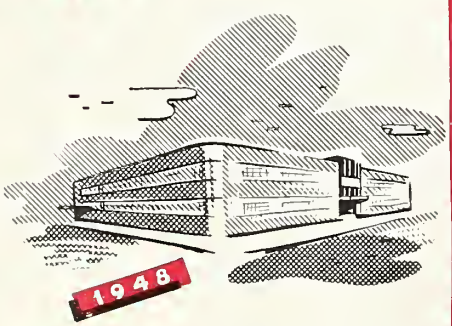
THE PRESIDENT: In conclusion, I wish to thank this House. I am very proud of our great association. . . . I thank you, I thank you.

No further business appearing, the House adjourned sine die.

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BRANCHES AT LOS ANGELES AND DALLAS

EXECUTIVE COMMITTEE

October 27, 1947.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; Floyd T. Romberger, M.D.; Cleon A. Nafe, M.D.; Alfred Ellison, M.D.; N. K. Forster, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: Norman M. Beatty, M.D., co-chairman, Legislative Committee, and A. P. Hauss, M.D., co-chairman, Convention Arrangements.

Membership Report

Number of members October 24, 1947	3,583*
Number of members October 24, 1946	3,455
Gain over last year	128
Number of members December 31, 1946	3,509

*Includes 119 in military service (gratis)
172 honorary members

1947 Annual Session, French Lick, October 28, 29, 30, 1947

Scientific exhibit awards. The convention co-chairman explained that certificates were being awarded to scientific exhibitors for the first time, and revealed other convention details.

Statements of receipts and expenditures for September for the Association committees and THE JOURNAL were approved.

Legislative Matters

National

Second annual essay contest of the A. A. P. and S. On motion of Drs. Romberger and Nafe the committee voted to table the request of the American Association of Physicians and Surgeons for the Indiana State Medical Association to co-operate in their second annual essay contest.

Local

Letter from Mrs. Mary Frame, president of the Indiana Association of Licensed Nursing Homes, requesting the co-operation of the association in putting through a program for specialized training for nursing home attendants, was read, but no action was taken.

The executive secretary was directed to see the Secretary of State and ask that he issue instructions to the Division of Safety Responsibility of the Bureau of Motor Vehicles forbidding the subpoena of physicians to testify in lapse of memory cases.

Motion was made by Drs. Nafe and Portteus that the Executive Committee supplement its report to the House of Delegates urging that legislation be sponsored in the 1949 Indiana General Assembly requiring that any person using the prefix "Doctor" be required to use an initialed suffix explaining the kind of "doctor" degree he holds.

Organization Matters

Nomination for A. M. A. general practitioner award. Indiana's formal nomination of Dr. J. T. Oliphant of Farmersburg for this award was signed by the various officers.

On motion of Drs. Nafe and Portteus, the executive secretary is to attend the annual luncheon meeting of the Indiana State Chamber of Commerce on November 14, and the state association is to continue its membership in the State Chamber of Commerce for 1948.

Fifty-Year Club. It was reported that more than 180 physicians are eligible to receive this award.

Resolution adopted by California Medical Association on Red Cross blood bank was read but no action taken.

Weekly column entitled, "Medicine in the News," offered to the association by an employee of the American Medical Association was turned down on motion of Drs. Nafe and Portteus.

Medical Meetings

Conference on School Health and Physical Education, Highland Park, Illinois, October 16-18, 1947. The executive secretary gave a report on this conference.

Conference on Home Town Medical Care of Veterans, Chicago, November 6, 1947. On motion of Drs. Nafe and Portteus, the executive secretary was instructed to attend this meeting.

The Journal

Report on advertising:

Additions	$ 862.80
Decreases	95.20
Total increase in October	$ 767.60
Total increase for year	$2,096.41

The request of the Richard A. Calkins Agency of the Massachusetts Indemnity Insurance Company for permission to distribute with a sales letter a reprint of an article by the attorney of the Indiana State Medical Association entitled, "Loop-Holes in Disability Insurance," in the November issue of THE JOURNAL was denied on motion of Drs. Nafe and Romberger.

On motion of Drs. Nafe and Portteus it was voted to recommend to the Council that the annual payment per member to THE JOURNAL be $3.00 instead of $2.00.

There being no further business the meeting was adjourned.

BUREAU OF PUBLICITY

October 10, 1947

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following "Hints on Health" releases were approved:

Week of November 17, 1947—"Infant's Diet."
Week of November 24, 1947—"Osteoarthritis."
Week of December 1, 1947—"Whooping Cough."

The following news articles and release dates were approved:

For October 17, 1947—"Active Program Faces Wives at Doctors' Meeting."

To | Oral Effectiveness and High Potency



ADD...a "plus"

An increasing number of investigators are commenting on the general "sense of well-being" which is usually experienced by menopausal patients following "Premarin" administration. This is a "plus" in therapy which is most gratifying to the woman crossing the threshold of the climacteric.

"Premarin" is supplied as follows:
Tablets of 2.5 mg. bottles of 20 and 100
Tablets of 1.25 mg. bottles of 20, 100 and 1000
Tablets of 0.625 mg. bottles of 100 and 1000
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful) . . . bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens ... estradiol, equilin, equilenin, hippulin ... are also present in varying small amounts, probably as water-soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

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Ayerst

CONJUGATED ESTROGENS (equine)

"Premarin"®

AYERST, McKENNA & HARRISON Limited

22 EAST 40TH STREET, NEW YORK 16, N. Y.

For October 23, 1947—"Association Will Honor Physicians Long in Practice."

For October 25, 1947—"Medical Meeting Affords Doctors Chance to Relax."

For October 27, 1947—"Indiana Doctors Ready for Ninety-Eighth Annual Meeting."

Public relations literature issued by the Medical Society of Pennsylvania was read.

Opposition of Sullivan County News to proposed $470,000 addition to Sullivan County Hospital was noted.

BUREAU OF PUBLICITY

October 24, 1947

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following "Hints on Health" releases were approved:

Week of December 8, 1947—"High Blood Pressure."

Week of December 15, 1947—"Bronchitis."

Week of December 22, 1947—"Sleeplessness."

Script of the Woman's Auxiliary broadcast on "Blue Cross and the Doctor's Plan" over WFBM, was approved. (Given October 20, 1947.)

The bureau directed the secretary to refer the Williamsport woman asking for medical information to her family physician.

"Medicine in the News," a feature written by a member of the A.M.A. staff, was read and referred to associate editor of THE JOURNAL for his opinion.

COUNCILOR DISTRICT MEETING

THIRTEENTH DISTRICT

Dr. A. A. Thompson of Tyner was elected president of the Thirteenth District Medical Society at the annual meeting held in South Bend Wednesday, November 12. Dr. Samuel T. Miller of Elkhart was elected vice-president; Dr. O. E. Wilson, also of Elkhart, was re-elected secretary-treasurer, and Dr. Alfred Ellison of South Bend was re-elected councilor.

South Bend was selected for the 1949 meeting place. The date will be Wednesday, November 10.

Speakers at the dinner, over which Dr. Ernest Dietl of South Bend, the retiring president, presided, included Dr. Roscoe L. Sensenich of South Bend, president-elect of the American Medical Association; Dr. George F. Lull, secretary and general manager of the A.M.A.; Dr. Floyd T. Romberger of Lafayette, president of the Indiana State Medical Association; Dr. Cleon A. Nafe of Indianapolis, president-elect of I.S.M.A., and Ray E. Smith, executive secretary of the state association.

In the morning a clinico-pathological conference was held at the South Bend Medical Foundation, the program consisting of bilirubin metabolism and liver function tests, with case reports by Dr. C. S. Culbertson of South Bend, and the new cardio-lipin antigin in the serologic diagnosis of syphilis by Dr. A. S. Giordano, also of South Bend.

The following program was given in the afternoon:

"Gelatin Sponges in Control of Hemorrhage," by Dr. Hilger P. Jenkins, clinical associate professor of surgery, University of Illinois College of Medicine, Chicago.

"Use and Abuse of Sex Hormones," by Dr. Willard O. Thompson, clinical professor of internal medicine, University of Illinois College of Medicine, Chicago.

"Fertility Problems in General Practice," by Dr. James L. Reycraft, associate professor of obstetrics and gynecology, Western Reserve University School of Medicine, Cleveland.

LOCAL SOCIETY REPORTS

Boone County Medical Society members held a dinner meeting on October seventh, at the Ulen Country Club, in Lebanon. The speaker for this meeting was Dr. Thomas B. Noble, Jr., of Indianapolis, who spoke on "The Navajo Indian Reservation." His talk was illustrated by colored films. Forty-three members and guests, including wives of the members and nurses from the Witham Hospital, were present.

The members held a dinner meeting on November fourth at the Witham Hospital, in Lebanon. The fifteen members present heard Dr. E. W. Dyar, of Indianapolis, discuss "Practical Eye Procedures."

Cass County Medical Society members met at the St. Joseph Hospital, in Logansport, on October seventeenth. The fifteen members present heard Dr. Paul J. Fouts, of Indianapolis, discuss "The Use of Folic Acid, Iron, and Liver in Anemias."

Greene County Medical Society members held a dinner and business meeting on October sixteenth, at the Freeman Greene County Hospital, in Linton. Twelve members attended the meeting.

The members held another meeting on November thirteenth, for their regular business meeting at the Freeman Greene County Hospital, in Linton. Dr. F. A. VanSandt, of Bloomfield, spoke on "Traumatic Injury of the Spleen." Twelve members were in attendance.

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FORMULAC Infant Food is a concentrated milk in liquid form, fortified with all vitamins known to be necessary to adequate infant nutrition. No supplementary vitamin administration is required.

By incorporating the vitamins into the milk itself, the risk of human error or oversight is reduced. FORMULAC contains sufficient B complex, Vitamin C in stabilized form, Vitamin D (800 U.S.P. units), copper, manganese and easily assimilated ferric lactate—rendering it a flexible formula basis both for normal and difficult feeding cases. The only carbohydrate in FORMULAC is the natural lactose found in cow's milk. *No carbohydrate has been added.*

FORMULAC, a product of National Dairy research, has been tested clinically, and proved satisfactory. It is promoted to the medical profession alone. FORMULAC is on sale at grocery and drug stores nationally.

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NEW YORK, N.Y.

Fort Wayne (Allen County) Medical Society members held a business meeting at the Chamber of Commerce, in Fort Wayne, on September thirtieth. Thirty-five members were in attendance.

On October seventh the members met at the Anthony Hotel, in Fort Wayne. The guest speaker of the evening was Dr. Eugene B. Ferris, Jr., of Cincinnati, whose subject was "Evaluation and Management of Hypertensive Vascular Disease." Seventy-one members attended the meeting.

At another meeting held at the Chamber of Commerce, in Fort Wayne, the members heard Dr. Gah T. Bowers, of Fort Wayne, discuss "Dysmenorrhea." Forty-nine members were present.

On November fourth the members again met at the Chamber of Commerce, in Fort Wayne. Dr. Richard Kent, of Fort Wayne, discussed unusual cases of edema. Forty-three members attended the meeting.

Hancock County Medical Society members met at the Riley Hotel, in Greenfield, on September seventeenth. Dr. R. J. McQuiston, of Indianapolis, spoke on "Diseases of the Neck." A business meeting followed.

Hendricks County Medical Society members held a luncheon on October seventh, at the City Cafe, in Danville. There was a demonstration of the inhaler and resuscitator which had recently been presented to the county for emergency use. Ten members and guests attended the meeting.

Indianapolis (Marion County) Medical Society members held a meeting at the Indiana University School of Medicine in Indianapolis, on October seventh. Dr. James L. Wilson, of Detroit, Michigan, was the guest speaker.

A second meeting was held on October fourteenth at the White Cross Service Center, at the Methodist Hospital, in Indianapolis. Dr. George J. Garceau, of Indianapolis, discussed "Reconstruction Operation for Irreducible Congenital Dislocation of the Hip"; Dr. J. Stanley Battersby, of Indianapolis, discussed "Atresia of the Esophagus"; and Dr. Joseph E. Tether, Jr., discussed "Myaesthenia Gravis."

Another meeting was held on November eleventh. The Staff of the St. Vincent's Hospital conducted the program on "Treatment of Bleeding Duodenal Ulcer."

Kosciusko County Medical Society members met on October twenty-first in Warsaw. Dr. George Plain, of South Bend, presented a paper on "Vagotomy in Peptic Ulcer." Honor was paid to Dr. J. R. King, of Silver Lake, in recognition of his fifty-three years of practice.

Laporte County Medical Society members held a dinner meeting on October sixteenth, at the Hotel Rumely, in LaPorte. The speaker for this meeting was Dr. Edward W. Custer, of South Bend, whose subject was "Modern Trends in the Treatment of Tuberculosis."

Morgan County Medical Society members held a meeting at the home of Dr. Charles W. Comer, in Mooresville, on November fifth. The speaker for this meeting was Dr. David Eisenberg, of Martinsville, whose subject was "Conservative Management of the Acute Perforated Peptic Ulcer." Six members attended this meeting.

Parke-Vermillion County Medical Society members held a dinner meeting on September twenty-fourth, at Aragon Park, in Clinton. The speaker for this meeting was Dr. James Engeler, of Lafayette, whose subject was "Fungus Infections of the Skin." The meeting was attended by twelve members.

On October twenty-second the members held a dinner meeting at the Vermillion County Hospital, in Clinton. Dr. Stuart Combs, of Terre Haute, spoke on "The Heart in Pregnancy." Ten members were present.

Vanderburgh County Medical Society members met on November eleventh at the McCurdy Hotel, in Evansville. "Management of Congestive Heart Failure" was discussed by Dr. Herman Baker, Dr. P. J. V. Corcoran, and Dr. Earl H. Antes, of Evansville. Sixty members were present.

Wayne-Union County Medical Society members held a dinner meeting at the Reid Memorial Hospital, in Richmond, on September eleventh. Twenty-seven members attended this meeting and heard Dr. Lyman T. Meiks, of Indianapolis, discuss "Poliomyelitis."

The Wells County Medical Society members held a Fall Clinical Conference on October seventeenth at the Country Club, in Bluffton. The program for this meeting was as follows: "X-ray Manifestations of Disorders of the Small Bowel," by Dr. Harry B. Weber, of Rochester, Minnesota; "Infertility," by Dr. Robert B. Wilson, of Rochester, Minnesota; "Acute Appendicitis and Its Complications in Infancy and Childhood," by Dr. Harry A. Oberhelman, of Chicago, Illinois; "Rheumatic Fever," by Dr. Charles A. R. Connor, of New York City; "Problems in the Field of Medical Education," by Dr. John D. VanNuys, of Indianapolis; and "The Spleen, Hypersplenism, and the Blood Dyscrasias," by Dr. Bruce K. Wiseman, of Columbus, Ohio. Sixty-six members and guests attended the meeting.

"Ain't that something? *My* muscles aren't flabby fat—'cause (thanks to you) I have plenty of protein in my *Biolac*."

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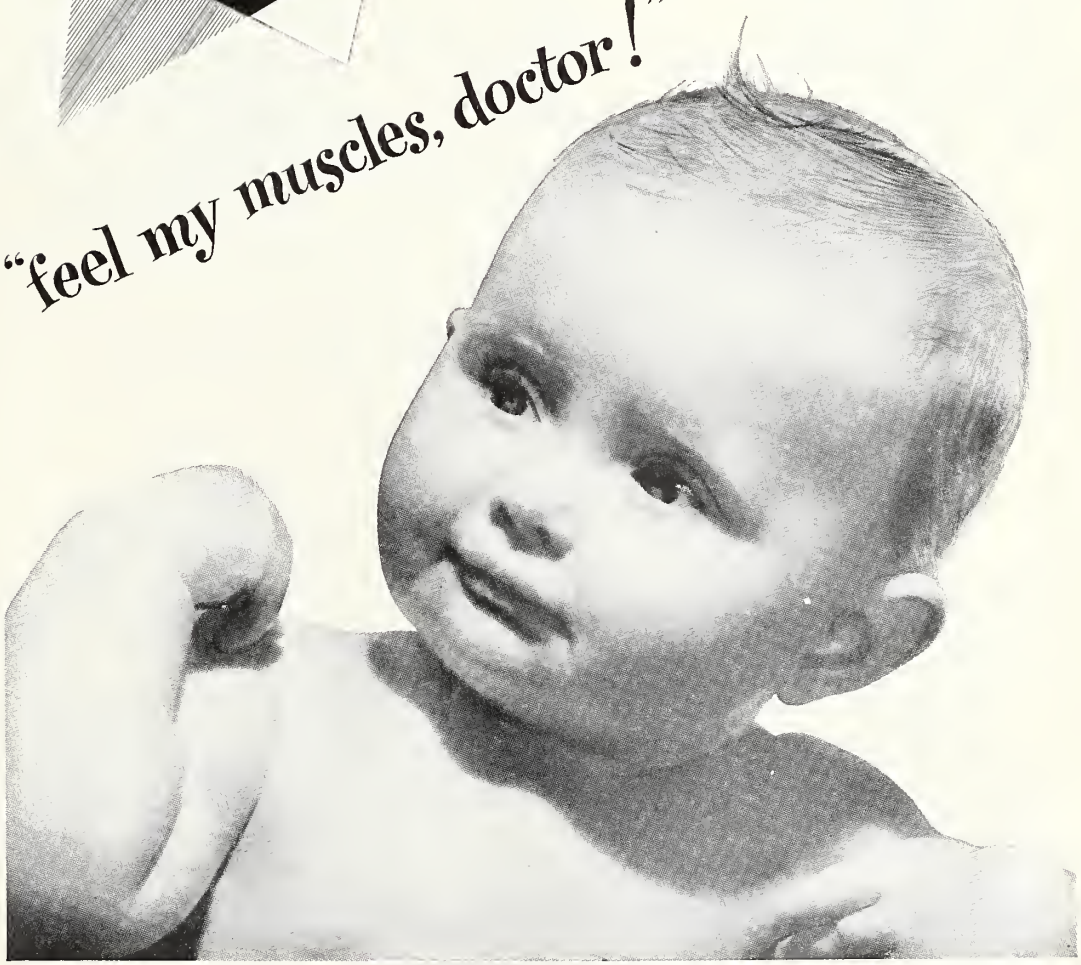
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WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. A. W. Ratcliffe, Evansville.
President-elect—Mrs. William Morrison, Kokomo.
Corresponding Secretary—Mrs. J. W. MacDonald, Evansville.
Recording Secretary—Mrs. Truman Caylor, Bluffton.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. F. M. Gastineau, Indianapolis.

President's Letter:

To each Hoosier doctor's wife I wish a Christmas of good cheer and a New Year of happiness and prosperity. The year 1947 has been a year of advancement for the Woman's Auxiliary to the Indiana State Medical Association. The year 1948 must bring us ever closer to our goals.

REBECCA RATCLIFFE, *President.*

Vanderburgh County

The following program has been planned by the Vanderburgh Medical Auxiliary:

December 9—Membership Tea at home of Mrs. Charles P. Schneider in honor of the State President, Mrs. A. W. Ratcliffe, and new members. Hostesses: Executive Board.

January 13—Tour of Deaconess Hospital. Hostesses: Mrs. John Visher, Chairman; Mrs. Chas. Sutter, Mrs. D. G. Tweedall.

February 14—Sweetheart Dance: The McCurdy Gold Room. Chairman: Mrs. Russell Springstun.

March 9—Dinner: Hotel McCurdy. Election of Officers. Speaker: Lowell Turner, Executive Secretary of Council of Social Agencies. Hostesses: Mrs. William Cockrum, Chairman, Mrs. Alvin E. Newman, Mrs. Karl Hefti.

April 13—Luncheon—Pot Luck at home of Mrs. Edgar Engel. Playlet: "Waiting Room Woes." Hostesses: Mrs. R. K. Dodd, Mrs. Ray Burnikel, Mrs. Wm. Healy.

May 11—Dinner: Hotel McCurdy. Speaker: Dr. L. E. Burney, State Health Commissioner. Hostesses: Mrs. Ermil Leslie, Chairman, Mrs. Dwight Anderson, Mrs. R. H. Schirmer.

June 8—Picnic: Gun Club. Hostesses: Mrs. C. C. Herzer, Chairman, Mrs. Thos. Wesson, Mrs. Earl Antes, Mrs. H. T. Combs, Mrs. Dallas Fickas.

Hoosier doctor's wives attending the medical convention at French Lick in October enjoyed a well balanced program, with plenty of fun and entertainment mixed with informative programs. We owe a vote of thanks to Mrs. James W. Baxter, Jr., of New Albany, and her committee for planning such enjoyable social activities, and to Dr. Hauss and his convention committee for the extra effort they put forth to see that the women had a wonderful time.

Mrs. A. W. Ratcliffe, president of the Woman's Auxiliary to the Indiana State Medical Association, opened the session with a board meeting at 1:00 p.m., Tuesday, October 28. That evening the women attended a dinner with their husbands in the main dining room. A floor show, "The Inaugural Frolic of 1947," was presented following the dinner. Everyone seemed to enter into the spirit of the program and as was promised, "A cavalcade of fun" for the doctors and their guests resulted.

The Bamboo Room was filled to capacity one-half hour before luncheon time Wednesday. The lucky women able to gain admittance enjoyed entertainment provided by a mind reader after lunch.

Mrs. Ratcliffe should be congratulated for the success of the first school of instruction held that afternoon. Three separate meetings were held simultaneously by the:

1. Administrative group under the leadership of Mrs. Voyles.
2. The organization group led by Mrs. W. R. Morrison.
3. The public relations and publications group led by Mrs. Ratcliffe.

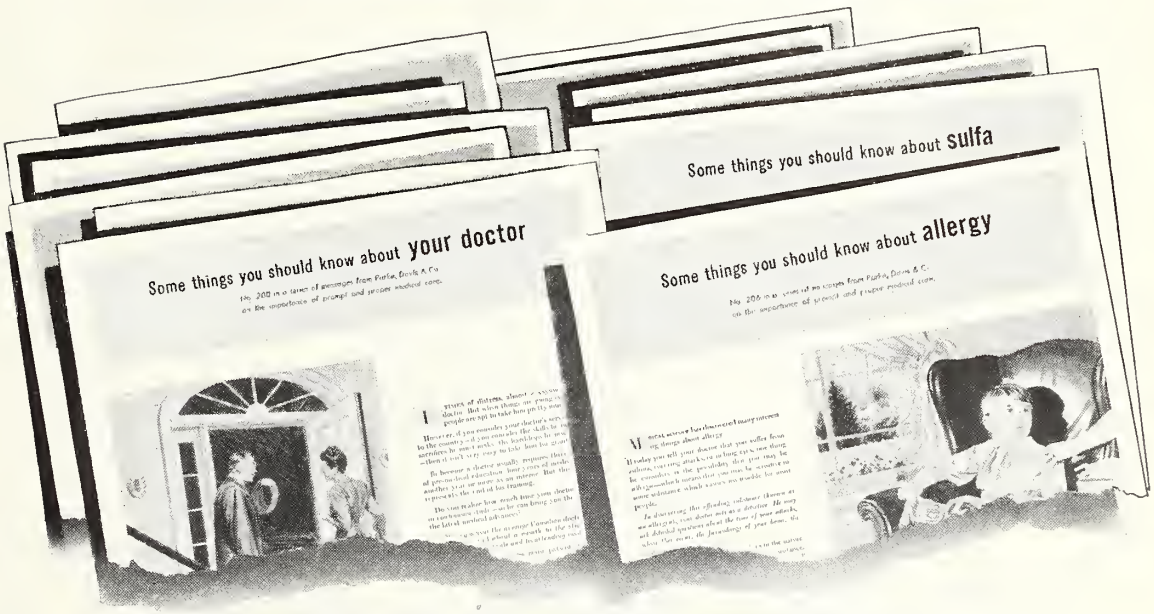
Officers and chairmen attended these meetings to receive suggestions for carrying on the auxiliary program.

Mr. Toner Overly was the principal speaker at the auxiliary dinner that evening. His subject, "Medical Quackery," was a topic of interest to all doctors' wives.

The session ended with a day for complete relaxation. A party was held Thursday afternoon, and the annual banquet was held in conjunction with the Indiana State Medical Association in the evening.

"See Your Doctor"

A Continuing educational campaign

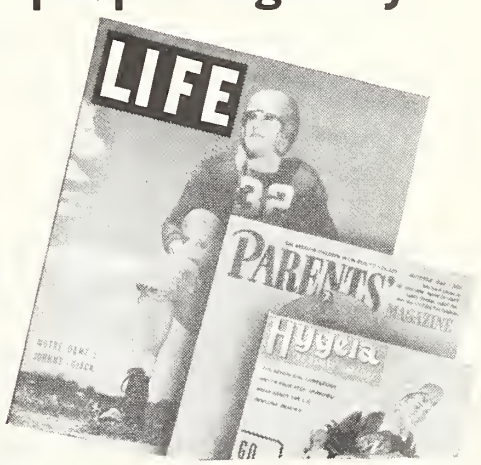


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INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—SEPTEMBER, 1947

Diseases	Sept. 1947	Aug. 1947	July 1947	Sept. 1946	Sept. 1945
Brucellosis	6	6	7	18	6
Chickenpox	10	32	27	35	34
Diphtheria	17	11	10	18	31
Diarrhea (Infectious)	3	4	...	...	...
Dysentery (Bacillary)	1	1	1	...	16
Encephalitis	7	...	...	19	6
Food Poisoning	12	2	...	3	1
Impetigo	11	13	3	8	2
Influenza	53	1	3	20	12
Measles	11	48	156	16	16
Meningitis (Cerebro-Spinal)	4	7	1	9	13
Meningitis (Influenza)	2	...	...	...	...
Meningitis (Lymphocytic Choreo)	1	...	...	...	...
Meningitis (Pneumococcus)	1	...	...	...	...
Mumps	9	10	22	18	30
Paratyphoid	2	...	...	...	1
Pertussis	170	250	220	88	87
Pneumonia	27	15	12	10	7
Poliomyelitis	96	59	8	131	77
Rocky Mountain Spotted Fever	1	3	5	2	...
Scarlet Fever	50	48	58	89	87
Tetanus	2	4	...	3	3
Tinea Capitis	6	...	13	...	3
Tularemia	1	1	1	1	0
Typhoid Fever	18	28	8	9	17
Tuberculosis (Pulmonary)	225	252	191	291	214
Tuberculosis (Other Forms)	9	7	9	20	6

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—October, 1947

Diseases	Oct. 1947	Sept. 1947	Aug. 1947	Oct. 1946	Oct. 1945
Brucellosis	10	6	6	19	4
Chickenpox	95	10	32	143	82
Diphtheria	43	17	11	48	55
Dysentery (Amebic)	2	...	...	3	...
Dysentery (Bacillary)	1	1	1	...	14
Encephalitis	2	7	1	...	3
Erysipelas	2	...	...	2	...
Conjunctivitis	6	...	...	3	1
Impetigo	21	...	...	21	1
Influenza	46	53	1	18	26
Malaria	1	...	...	12	17
Measles	24	11	48	26	17
Meningitis, Meningococcic	1	...	...	7	8
Mumps	19	9	10	18	22
Paratyphoid	2	2	...	...	...
Pertussis	2	2	...	63	113
Pneumonia	48	27	15	24	11
Poliomyelitis	42	96	59	99	36
Rabies (animal)	14	...	...	...	...
Rubella	6	...	2	1	1
Scarlet Fever	109	50	48	200	217
Septic Sore Throat	9	...	7	1	13
Tinea Capitis	65	6	...	...	...
Tularemia	1	1	1	2	0
Typhoid Fever	3	18	28	21	6
Vincent's Angina	5	...	2	18	1
Tuberculosis (Pulmonary)	170	225	252	158	135
Tuberculosis (Other forms)	9	9	7	6	3

CHICAGO MEDICAL SOCIETY

FOURTH ANNUAL CLINICAL CONFERENCE

March 2, 3, 4, 5, 1948

Palmer House, Chicago

Four full days of lectures, panel discussions and clinicopathologic conferences presented by outstanding speakers and teachers from all sections of the country.

Scientific exhibits well worth seeing.

Technical exhibits on the newer drugs and equipment.

If you have attended previous Conferences, you probably are planning to come again in 1948. If you have not yet attended, you should make plans now to be present.

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